Looking Back, Looking Forward - Integrated Care Systems as the Platform for Reform of Health and Social Care

Annual Report For The Health Devolution Commission
In-Person, In Parliament Event, January 17th 2024

Contents

1 The January 2024 Meeting

17:00 to 19:00, Wednesday 17th January 2024
Committee Room 5, Houses of Parliament

This annual report of the Health Devolution Commission will be discussed at a meeting chaired by the Commission's three Co-chairs: **Rt Hon Andy Burnham**, former Health Secretary and Mayor of Greater Manchester; **Rt Hon Sir Norman Lamb**, former Health Minister and Chair, South London and Maudsley NHS Trust; and **Imelda Redmond CBE**, former National Director, HealthWatch, and Board Member, North East London ICS.

The aim of the meeting is to *look back* at the main learning points from the Commission's three roundtables in 2023 and then, using that evidence, *look forward* to the seven major challenges facing ICSs in 2024 as set out in this report. There are ten questions that the Commission has concluded require answers in order for ICSs to be the right platform for future improvement in health and social care.

The meeting will begin with Phil Hope, former Minister of State for Care Services and chief author of the Health Devolution Commission Secretariat's reports, highlighting the key points in the report: *Looking Back, Looking Forward - Integrated Care Systems as the Platform for Reform of Health and Social Care.*

After this, the roundtable will hear the reflections of an expert panel consisting of **Professor Michael Marmot**, Director of the UCL Institute of Health Equity, **Matthew Taylor**, Chief Executive of the NHS Confederation and **Dr Nik Johnson**, GP and Mayor of Cambridgeshire and Peterborough Combined Authority.

There will then be keynote contributions from a Parliamentary panel consisting of **Helen Whately MP**, Minister for Social Care and Integration, **Andrew Gwynne MP**, Shadow Minister for Care and Integration, **Daisy Cooper MP**, Spokesperson on Health for the Liberal Democrats and **Steve Brine MP**, Chair of the Health and Social Care Select Committee.

Both panels will set out their views regarding what they consider needs to change in 2024 (or after the General Election) so that Integrated Care Systems are the best possible platform for partners to work jointly together for the better delivery of NHS, social care and public health services to achieve their shared aims. They will also address some or all of the Commission's key questions. There will also be plenty of time for questions and contributions from all attendees.

2 Looking Back – In Summary

At the launch in Parliament of its annual report last year – *'ICSs: a great deal done – a great deal more to do'*[1] - the Commission concluded that:

"a great deal has been done during 2022 to develop ICSs as the new platform for delivering better, more joined up and person-centred health and social care services as well as improving the community's health and wellbeing. However, the combined impact of the Covid 19 pandemic and the cost-of-living crisis is putting severe pressure on both the health and wellbeing of families and communities, and the financial sustainability of health and social care services. There is a real risk that the gains made could be lost in 2023."

It was therefore agreed that there would be a programme of meetings for 2023 to focus on a range of key issues facing ICSs and help develop, as well as highlight, emerging, best practice. Each meeting included expert analysis and examples of best practice with reference to the crosscutting themes of health inequalities, workforce development, people with learning disabilities/autism, children and young people, and mental health. Each meeting also looked at a key topical issue.

The six main conclusions from these meetings are:

• **March – the Hewitt Review; and ICSs and the cost-of-living crisis.**

- The Hewitt Review of integrated care systems was a detailed and helpful analysis of the steps needed to take health devolution to the next stage of development. It has insights and recommendations for action at every level that the Commission welcomes and looks forward to Government action to further its many recommendations.

- Each ICS should put the evidence about the impact of the cost-of-living crisis on health on their agenda, make poverty a mainstream agenda item of every provider and commissioner of services in their system, and seek to answer the question 'what are we doing about reducing the impact of poverty on health in our area'?

• **June - Social care reform; and ICSs and social and economic development.**

- The Commission will seek to influence plans to reform the social care system to ensure it contains the right balance of national funding, leadership, universal care and pricing standards, and national workforce terms and conditions; and local decision making and resources through devolution to local partnerships with the flexibility to design and deliver services and interventions to meet local priorities and population needs.

[1] https://healthdevolution.org.uk/wp-content/uploads/2022/12/DEVO-Health-Devolution-Commission-Annual-Report.pdf

- ICS statutory partners - NHS and local government – can directly help local social and economic development through providing employment that is sustainable, well-paid and satisfying. ICSs can ensure that the real living wage levels apply to the services they commission and in the contracts with external suppliers such as cleaning companies. Delivering this - and the wider reform of social care - will require local authorities and the NHS to be given additional resources.

- **September – Progress towards integration; and ICSs and better housing for better health**.

  - In order for there to be a shift from a narrow NHS focus to a wider joint ambition between the NHS, local government and the VCFSE sector to improve the public's health, and the health of places in which they live and work, the Commission would like to see every ICS make visible - and, if necessary, strengthen - the relationship and accountability between their IC Board and their IC Partnership.

  - The Commission believes that better housing should be higher on the agenda of ICSs as the direct causal link between poor housing and poor health is now clearly established. Taking action on this issue could include ICSs developing their own combined health and housing data sets and a 'Better Housing for Better Health' strategy as well as a number of immediate actions.

At each meeting recommendations were also made for the Government and/or NHSE. The main ones were:

- The Government should support the development of Local ICS Outcome Frameworks within a National ICS Outcome Framework which includes no more than 10 national targets.

- The Government should develop greater understanding of what good looks like in building personal and community resilience, and the role the state in all its forms can play to support it

- Creating a social care workforce strategy - aligning nationally the terms and conditions of the social care workforce with the NHS workforce - will be very supportive of ICSs developing a joint workforce strategy for their areas.

- Government support for ICSs seeking to achieve their 4th primary purpose is essential and would be helped through Departments working in a more joined up way to acknowledge and support this purpose as recommended by the Hewitt Review.

- The Commission would like the Government and NHSE to reflect a person-centred approach in the future development and funding of the Major Conditions Strategy.

- The Commission calls upon the Government to create an internal cross-departmental working group from DHSC and DHLUC to put into practice measures that will support 'better housing for better health' at every level within Government.

To see the reports of all the meetings in 2023 please visit www.healthdevolution.org.uk

3 Looking Forward

The NHS and social care landscape

The State of the Population's Health

The 2021 *'Health Profile for England'* report from Public Health England[2] provides the most recent comprehensive snapshot of the nation's health in England including analyses of mortality and life expectancy, child health, health in adults, risk factors associated with ill health, the wider determinants of health, health protection, and the impact Covid-19. A summary of the key findings with particular reference to health inequalities is given below:

Life expectancy: Although the size of England's older population has been increasing, improvements in life expectancy have slowed down. Moreover the gap in life expectancy between the most and the least deprived areas has grown with a level of inequality now larger than in all previous years in the last 2 decades.

Child health: Recent decades have seen overall improvements in babies born with a low birthweight, infant deaths, child development and dental health. However, in the years leading up to the coronavirus pandemic improvements in these indicators had slowed. NHS England[3] estimate that 1.7 million children have longstanding illnesses, including asthma, epilepsy and diabetes, and that England lags behind international comparators in some important aspects of child health. Young people are increasingly exposed to two new childhood epidemics – obesity and mental distress.

Wide inequalities are apparent across all indicators of child health. In the most deprived areas, the proportion of term babies with a low birthweight, the infant mortality rate, and the prevalence of obesity in children aged 4 to 5 and 10 to 11 years was more than double the least deprived. The prevalence of tooth decay was almost 4 times higher in most deprived areas than in the least deprived areas.

Health in adults: Healthy life expectancy measures the number of years spent in comprehensive health and this has shown little improvement in recent years. Healthy life expectancy is shorter in the most deprived areas and the gap with the least deprived areas was 19 years for both males and females. The UK had the lowest reported healthy life expectancy out of 8 comparable countries for women and the second lowest for men.

The top 3 causes of ill health (excluding mortality) for men were low back pain, diabetes mellitus and depression, and for women were low back pain, headache and gynaecological diseases. Nearly 1 in 5 adults aged 16 to 64 years in England had at least one common mental health disorder (CMD) such as depression, anxiety, phobias, obsessive compulsive disorder or panic disorders; and the prevalence of a CMD in adults over the last 20 years has increased.

As the number of older people has increased, the number of people living with ill health or one or more long-term health conditions has also increased. Dementia is a leading cause of death and a significant cause of ill-health in England. Cancers are also a significant cause of ill health and mortality in England and the number of cancers diagnosed has been increasing year-on-year.

[2] https://fingertips.phe.org.uk/static-reports/health-profile-for-england/hpfe_report.html
[3] https://hubble-live-assets.s3.amazonaws.com/collaborative/redactor2_assets/files/28/Transformation_Programme.pdf

A report by Age UK *'The State of Health and Care of Older People'*[4], 2023 says that 86% of people over 85 in England live with at least one long-term health condition and that 1.6 million people aged 65+ have unmet needs for care and support.

Risk factors: Risk factors play an important role in determining whether a person becomes ill, at what age, and the associated effect on quality of life. The Global Burden of Disease (GBD) divides risk factors into 3 main groups: behavioural, metabolic, and environmental and occupational. These are underpinned by the broader social and economic risk and protective factors that shape people's lives such as education, income, work and social capital.

Prior to the pandemic, there was an upward trend in obesity in adults while the prevalence of smoking in adults declined. The prevalence of 'increasing or higher risk' drinking in adults saw a slight reduction on previous years, while there was evidence of an increase in drug use. The proportion of adults meeting recommended level of physical activity and fruit and vegetable consumption remained fairly constant.

Inequalities in risk factor prevalence contribute to inequalities in ill health and mortality. Smoking prevalence remained much higher than average in some groups such as people in manual occupations, people with a long-term mental health condition, deprived areas, and the 'mixed ethnic' groups. The prevalence of 'increasing or higher risk' drinking was greatest in the highest household income group. The prevalence of obesity in adults was higher in the most deprived than least deprived areas, and there were wide inequalities in the proportion of adults meeting recommended level of physical activity and fruit and vegetable consumption.

Wider determinants of health: The wider determinants of health are a diverse range of social, economic and environmental factors which influence people's mental and physical health across the life course. The employment rate in England was higher in men and in the least deprived areas. In 2018 to 2019, 42% of all children and 68% of children in lone parent households were living below the minimum income standard for healthy living, compared with 29% of working age adults.

Health protection: Health protection issues include the prevention and control of all types of infectious diseases, and chemical and environmental threats to the health of the population. It is estimated that long-term exposure to the air pollution mixture in the UK has an annual effect equivalent to 28,000 - 36,000 deaths. The highest air pollution exposures have been in deprived urban environments therefore contributing to health inequalities.

Prior to the pandemic the incidence of many infectious diseases such as TB had been declining, but disproportionately impacted more deprived or excluded health groups. There was an increase in the rate of new diagnoses of preventable bacterial sexually transmitted and the rate of new STI diagnoses in the third most deprived areas was more than double the rate in the least deprived areas. As a result of effective vaccination programmes the incidence of many diseases has reduced significantly over time.

Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the most deprived 20% – and identifies '5' focus clinical areas requiring accelerated improvement: maternity; chronic respiratory disease; early cancer diagnosis; and hypertension. This approach, which initially focussed on healthcare inequalities experienced by adults, has now been adapted to apply to children and young people.

[4] https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/health--wellbeing/age-uk-briefing-state-of-health-and-care-july-2023-abridged-version.pdf

The State of the NHS and Social Care System

The 'Care Quality Commission report on the *'State of Care 2022/23'*[5] and adult social care is a comprehensive assessment of access to care, care quality and care inequalities in England:

Access to care: Getting access to services remains a fundamental problem, particularly for people with protected equality characteristics. Along the health and care journey, people are struggling to get the care they need when they need it:

- Record numbers of people are waiting for planned care and treatment, with over 7 million people on elective care waiting lists in June 2023. The true number of people could be much higher, as some people who need treatment are struggling to get a referral from their GP.

- In the community, people are facing ongoing struggles with getting GP and dental appointments. 45% of older people were concerned about their ability to access their GP in a 2022 Age UK survey.

- Some people are using urgent and emergency care services as the first point of contact, or not seeking help until their condition has worsened. There are also widespread concerns – including from NHS England[6]- that ambulance response times are "risky" ie compromise safety.

- Once at hospital, people are facing longer delays in getting the care they need. In 2022, over half (51%) of respondents to a CQC urgent and emergency care survey said they waited more than an hour before being examined by a nurse or doctor, up from 28% in 2020.

- Insufficient capacity in adult social care is continuing to contribute to delays in discharging people from hospital. Ongoing staffing and financial pressures in residential and community services are having an impact on the quality of people's care, with some at greater risk of not receiving the care they need. The Sector Pulse Check - to be published by Hft and Care England in January 2024 – found 43% of adult social care providers closed a part of their organisation or handed back contracts in 2023.

- A recent survey by Young Minds[7] showed that more than a third of young people (37%) said they did not feel supported by their GP when they tried to access mental health support or advice; and more than two thirds of young people (71%) said they experienced problems with their relationships with family and friends as a result of having to wait for mental health support.

- Research by Mencap[8] has shown that people with a learning disability have worse physical and mental health than people without a learning disability and have a much shorter life expectancy. They also experience a wide range of barriers to getting good quality health care.

Quality of care: The quality of care that people experience is affected by many different factors:

- Increasing demand and pressures on staff are taking a toll on their mental health and wellbeing. Staff have said that without the appropriate support, this is affecting the quality of care they deliver.

- Many people are still not receiving the safe, good quality maternity care that they deserve, with issues around leadership, staffing and communication.

- Ingrained inequality and the impact on people from ethnic minority groups remains a key concern.

[5] https://www.cqc.org.uk/publications/major-report/state-care/2022-2023
[6] https://www.england.nhs.uk/reducing-ambulance-handover-delays-kloes/
[7] https://www.youngminds.org.uk/about-us/media-centre/press-releases/mental-health-waiting-times-harming-young-people/
[8] https://www.mencap.org.uk/learning-disability-explained/research-and-statistics/health/health-inequalities

- The quality of mental health services is an ongoing area of concern, with recruitment and retention of staff still one of the biggest challenges for this sector.

- Innovation and improvement varies, but the use of artificial intelligence (AI) in health care has the potential to bring huge improvements for people. Given the speed of growth of AI, the report emphasises the need to ensure that new innovations do not entrench existing inequalities.

Care inequalities: The 2022 CQC report stated that care inequalities pervade and persist. The 2023 report highlights some people who are more likely to face inequalities in access and experience when using health and care services:

- Midwives from ethnic minority groups say that care for people using maternity services is affected by racial stereotypes and a lack of cultural awareness among staff. They described a 'normalised' culture where staff tolerate discrimination from colleagues, and say they are less likely to be represented in leadership and managerial roles.

- People from ethnic minority groups who have a long-term condition felt they were talked down to about their treatment and were not treated as individuals. They also said a lack of cultural competency was a barrier to receiving good quality care.

- These people were also more than 2.5 times more likely to say that staff in the emergency department talked as if they were not there, compared with people from white ethnic groups.

- Failures in the system and a lack of funding can mean that budgets are prioritised above truly person-centred approaches to support in supported living services.

Care systems: The way health and social care works in England has changed significantly over the past year, with new integrated care systems now formalised. The report says that:

- Local systems should now implement plans to address unwarranted variations in population health and disparities in people's access, outcomes, and experience of health and social care.

- Local authorities are tackling workforce problems in adult social care and trying to address gaps in care as they plan for the future. But they will need to demonstrate an understanding and preparedness for the changing and complex needs of local populations.

- Assessing carers' needs is vital. Carers, including many unpaid carers, are a critical part of all local care systems and they are not always getting the support they need – there is variation across the country and many carers are facing financial problems.

- The effectiveness of urgent and emergency care services can indicate how effectively health and care services are co-ordinated across a local system. But people's experience in urgent and emergency care continues to be poor and the problems are pointing to issues that require a local system level response.

- There are ongoing problems with the current Deprivation of Liberty Safeguards system that have left many people who are in vulnerable circumstances without legal protection for extended periods.

The State of the NHS and Social Care Workforce

The NHS workforce

The NHS Agenda for Change created in 2004 is the pay scale for staff in the NHS[9]. The Government published the long-awaited *'NHS Long Term Workforce Plan'*[10] in 2023 that is a comprehensive 15 year plan for training, retention and reform to meet the workforce shortages and future demands for staff in the NHS. In March 2023 there were more than 1.27 million full-time equivalent staff working in NHS trusts in England with 112,000 vacancies[11]. The Plan shows that, without concerted and immediate action, the NHS will face a workforce gap of more than 260,000–360,000 staff by 2036/37.

The cross-party House of Commons Public Accounts Committee review of the plan expressed its concern that the government's published commitment to an investment of £2.4bn over five years contained no detail about when and how this money would be released, nor how the last 10 years of the plan would be funded.

The Committee echoed the concerns of many in the sector in saying that "The plan does not include any estimate of total additional running costs for the significant increase in workers it has identified, such as salaries for an extra 260,000 to 360,000 staff. There is no information available on either the scale or source of how staff costs in future years will be met."

The CQC report said in its summary of the state of the NHS workforce that:

- NHS staff regularly told the CQC that they are being overworked, exhausted and stressed, sometimes to the point of becoming ill, injured or leaving their job altogether.

- Staff said this can affect their ability to provide safe and effective care to people.

- Just over a quarter (26%) of NHS staff were satisfied with their level of pay. This is 12 percentage points lower than before the pandemic.

- Dissatisfaction with pay is linked to industrial action by healthcare staff during 2023.

Unresolved pay disputes for some NHS staff are continuing in 2024.

The adult social care workforce

The 2023 Skills for Care report *'the state of the adult social care sector and workforce in England'*[12] and the CQC report *'the state of care 2022/23'*[13] both highlight a number of key issues regarding the health and social care workforce:

Size: The adult social care sector was comprised of around 18,000 organisations across 39,000 care providing locations with 1.635 million filled posts and 152,000 vacant posts. The combined number of total posts (filled posts and vacant posts) in adult social care in England was 1.79m. The number of full-time equivalent filled posts was estimated at 1.19 million and the number of people working in adult social care was estimated at 1.52 million; more than in the NHS headcount of 1.43 million. Half of the workforce usually worked full-time hours and half were part-time. The adult social care workforce is comprised of 81% female workers, compared to 47% of the economically active population.

Contract status: Domiciliary care services had the highest proportion of workers employed on zero-hours contracts (42%), especially among care workers (50%).

[9] https://healthjobs.bmj.com/article/guide-to-nhs-pay-agenda-for-change-2023-2024
[10] https://www.england.nhs.uk/wp-content/uploads/2023/06/nhs-long-term-workforce-plan-v1.2.pdf
[11] https://healthmedia.blog.gov.uk/2023/04/27/nhs-workforce-record-numbers-of-doctors-and-nurses-in-nhs/
[12] https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/publications/national-information/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx
[13] https://www.cqc.org.uk/publications/major-report/state-care/2022-2023

Staff turnover: The staff turnover rate of directly employed staff working in the adult social care sector was 28%. This equates to approximately 390,000 people leaving their posts over the course of the year. Not all people leaving their posts leave the sector. Around 59% of filled posts were recruited from other roles within the sector.

Staff Vacancies: On average, 10% of posts in adult social care were vacant in 2022/23, which is equivalent to 152,000 vacant posts being advertised on an average day. In 2022/23, approximately 70,000 people arriving to work in the UK from overseas started direct care roles in the independent adult social care sector, compared with around 20,000 in 2021/22.

Pay: The average (median) hourly rate of a care worker decreased, in real terms, by 3.3% between March 2022 and March 2023. This compares to an average increase of 1.1% per year since March 2016. This decrease was driven by the high cost of living in 2021/22 and 2022/23 with inflation rising to 10.1% in the 12 months to March 2023.

Economic value: The adult social care sector was estimated to contribute £55.7 billion gross value added (GVA) per annum to the economy in England (up 8.5% from 2021/22).

The CQC report on the adult social care workforce reinforces these assessments and adds the observations that:

- Some providers are struggling to pay their staff a wage in line with inflation.

- Over half said they were having challenges recruiting new staff, and 31% said they were having challenges in retaining them.

- Providers of adult social care services told the CQC that recruiting staff from overseas has enhanced the diversity and skills of their team and helped resolve staffing issues.

- There is a growing trend of unethical international recruitment practices. In 2022/23, the CQC made 37 referrals for concerns regarding modern slavery, labour exploitation and international visas – more than 4 times the number made in 2021/22.

Unpaid carers

The social care system in England is completely reliant on the support provided by unpaid carers. The 2021 census[14] shows that 1.4 million people in England provided 50 or more hours of unpaid care a week; and a total of 5 million people provide unpaid care each year, 59% of whom are women. This is the equivalent of a second NHS and is estimated to be worth around £162 billion.

Other organisations have made estimates of the numbers of people undertaking unpaid caring roles in their family:

- Carers UK research[15] suggest there may be as many as 10.6 million unpaid carers in the UK upon whom people and the system depend for care.

- Age UK[16] estimate that one in five (20%) of unpaid carers are aged 65 plus; and

- Action for Children[17] estimate that as many as one in five children and young people are young carers with around 800,000 young carers aged 11-16 in England, and an estimated 1 million young carers across the UK.

[14] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/bulletins/unpaidcareenglandandwales/census2021#:~:text=In%20England%20and%20Wales%20an,2011%20to%204.4%25%20in%202021.
[15] https://www.carersuk.org/policy-and-research/key-facts-and-figures/
[16] https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/health--wellbeing/age-uk-briefing-state-of-health-and-care-july-2023-abridged-version.pdf
[17] https://www.actionforchildren.org.uk/blog/young-carers-who-are-they-and-how-are-they-impacted/#:~:text=How%20many%20young%20carers%20are,11%2D16%20in%20England%20alone.

Challenges and opportunities for ICSs in 2024

The state of the public's health, the state of NHS and social care services and the state of the NHS and social care workforce provide a very challenging context within which ICSs will be operating in 2024.

1. Increasing demand for acute care

The first and biggest challenge is that of continuing with the reform journey to further integrate health, social care and public health services to benefit local people at a time of increased demand for all services (including primary, community and mental health as well as acute services). There is intense pressure to focus resources and capacity on reducing waiting times and waiting lists for NHS diagnoses and hospital-based treatments that will take resources away from action in other key service areas.

The Commission has previously highlighted the risk that focus and action on the goals it supports - of shifting care away from institutions into the community, improving the public's health to reduce demand on care services, and maximising the social and economic value of the NHS in local communities - will be downgraded by system leaders at national and local levels because of these demand pressures.

2. Funding reductions

ICSs are being asked to find a 30% reduction in their running costs allowance whilst at the same time endeavouring to produce and deliver integrated care plans for NHSE and local partners that focus on locally and nationally determined priorities. It is reported that much time and effort is being taken up by restructures and cost cutting to the detriment of significant change management. The ongoing industrial action places yet further strain on ICSs and also has negative financial implications.

Meanwhile pressure on NHS services – see 1 above - risks any additional funding for the NHS being directed solely towards acute care and funding for system reform activity being reduced. Moreover, if an acute trust goes into deficit this will affect the whole of the ICS and divert resources away from reducing inequalities, delivering population health improvement and supporting care closer to home.

In addition, the capacity to take full advantage of important and helpful initiatives such as the introduction of the NHS Provider Selection Regime – which provides a framework for collaboration to flourish across systems – is constrained given the financial pressures ICSs are under. It is also not surprising although unfortunate that the greater delegation of the commissioning of specialist hospital services[18] – announced on 7th December 2023 and meant to be taking place from April 2024 – is only being 'rolled-out' in three of the seven English regions.

Local government is expected to maintain and improve social care services, but with an increase to their budget of 6.5% for 2024 they will not be able to increase fee levels to match the increased costs being incurred by social care providers.

These costs include very high energy costs, the increased National Living Wage (9.8%) that many care and support staff receive, and the use of expensive agency staff to fill the gaps likely to result from recent tighter restrictions on recruiting overseas staff.

There are also wider concerns about overall funding for local authorities given the number that have filed section 114 notices – being declared bankrupt - in 2023. Without sufficient resources, councils cannot perform their public health, housing and environmental health functions in such a way as to make a positive impact on the wider determinants of ill health.

[18] https://www.england.nhs.uk/long-read/specialised-commissioning-2024-25-next-steps-with-delegation-to-integrated-care-boards/

The NHS Confederation have pointed out that the UK has invested less in health capital over several decades when compared with comparable nations. The result is a less productive service hampered by, among many other things, Victorian estates, too few diagnostic machines and outdated IT systems that still cannot communicate between hospitals and primary care. It is therefore calling on all political parties to commit to a £6.4 billion annual capital funding increase for the NHS at next year's three-year Spending Review.[19]

In conclusion the Commission is concerned that continued reform of the NHS and the system as a whole will stall during 2024 if the resources – both capital and revenue - to support change are reduced not increased; if the local government side of the partnership is unable to pay sustainable fee levels to social care providers; and if, as a result, there is further weakening of the essential reforming role of Integrated Care Systems.

3.   Workforce shortages

The high staff shortages and high turnover of care and support staff in social care resulting from low and unfair pay is contributing directly to the disruption of care services and the low morale of the care workforce. Unless the care workforce challenges are resolved it will not be possible for the social care system to deliver effective services or for the NHS to achieve its goals. This will in turn have an the effect of putting more burdens on unpaid carers with a personal cost to them and a financial cost to the economy.

The Commission has previously highlighted the impact and challenges of shortages in the social care workforce, and supported calls for the development of a national care workforce strategy that addresses the issue of low and unfair pay, echoes the NHS Long Term Workforce Plan and has widespread benefits for communities, services and the economy.

The ongoing pay disputes in the NHS are inevitably contributing to the challenging waiting times and lengthy waiting lists for NHS care and treatment. They will inevitably exacerbate the concerns of the CQC about poor access to care, poor quality of care, care inequalities and care system performance.

The Commission welcomes the initiatives by many ICSs to develop their own People Plans which will seek to address the health and social care workforce issues - including giving proper attention to the VCFSE sector - if they are to bring about the changes needed. However the Commission believes that to succeed in this respect, ICS and local authorities will require additional resources.

4.   Primary and community care reform

The Commission has always been keen to see a shift of resources and leadership away from institutional care towards community-based care that reflects greater integration between different clinical community services within the NHS; greater integration between health, social care and other public services such as housing; and greater integration between wider public health improvement activities and care services in the community.

The Fuller Stocktake[20] report describes the benefits and potential ways of delivering a new neighbourhood approach to primary and community care. The creation and evolution of Primary Care Networks (PCNs) on population footprints of 30-50,000 is a key structural part of this change.

The benefits of this approach were highlighted in the 2023 NHS Confederation Report 'Unlocking the power of health beyond the hospital'[21] which found that:

[19] https://www.nhsconfed.org/publications/investing-to-save-NHS-capital-England
[20] https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/
[21] https://www.nhsconfed.org/publications/unlocking-power-health-beyond-hospital

- Those areas that spent less on community care in terms of population need have seen higher-than-average levels of hospital and emergency activity, compared to those spending relatively more. On average, systems that spent more in community care saw 15% lower non-elective admission rates and 10% lower ambulance conveyance rates, both statistically significant differences, together with lower activity for elective admissions and A&E attendances.

- Despite the increased focus on creating better health value and unlocking system productivity, there is currently no relationship between the amount invested by NHS organisations in the community care and their population community care needs. The sheer variation in spend perhaps highlights a wider lack of understanding and prioritisation in community care.

- The reduction in acute demand associated with this higher community spend could fund itself through savings on acute activity if a causal relationship were assumed, with an average 31% return on investment and average net saving of £26m for an average-sized ICS, exemplifying the power and potential of community care at a system level.

- The NHS Confederation have calculated that for every £1 invested in community or primary care, there is up to a £14 return back into the local economy through gross value added (GVA).[23]

However, the development of PCNs has been happening in parallel to the development the dual structure of the ICSs – Boards and Partnerships - and their local authority-based place-based partnerships with separate funding streams and contractual arrangements with NHSE. Some ICSs have identified and allocated part of their resources to support PCNs but this varies considerably from one ICS to the next.

5. Public health improvement and prevention

The Commission has strongly supported the role of ICSs as a partnership between the NHS, Local Government and the VCFSE sector that delivers improvements to public health. Without action to identify and deliver improvements to the social determinants of ill-health and reductions in health inequality, the system will face an ever-growing demand for care and treatment that it will not be able to meet.

Whilst there are some public health and prevention activities and goals that are best driven from the centre (e.g., a tax on sugar to reduce consumption, reduce obesity and improve children's oral health), most of the action and resources are best deployed at a local level.

The nature of these goals and actions will need to reflect the wider determinants of ill-health. There is for example, an emerging public health and prevention role among some City Mayors and MCAs such as the Mayor of London, the Mayor of Greater Manchester, the Mayor of the West Midlands, and the Mayor of Cambridgeshire and Peterborough.

There are a wide variety of social prescribing interventions[22] that can be very effective in delivering a personalised, non-clinical approach to meeting the practical, social and emotional needs that affect people's health and wellbeing.

[22] https://www.england.nhs.uk/personalisedcare/social-prescribing/
[23] https://www.nhsconfed.org/news/extra-investment-out-hospital-care-can-reap-billions-wider-economy]

6.   Under-represented groups and conditions

Throughout its work the Commission has sought to shine a spotlight on the needs of particlular groups or conditions that are most likely to be overlooked in the health and social care system. These are groups disproportionality affected by health inequalities such as people from minority and disadvantaged communities, people with learning difficulties, children and young people in a system often focused on the needs of an ageing population, unpaid carers, and people with mental health needs who still experience stigma and discrimination.

There are many examples of innovative practice that ICSs can draw upon. For example, Barnardo's will be publishing in early 2024 a review of how well babies, children and young people are prioritised within ICSs and how extensively their needs have been considered in relation to workforce challenges, health equity and other challenges for ICSs.

The Commission has sought to ensure that the health and care needs of such groups are routinely considered when exploring how health devolution can be best be achieved; and to ensure the voice of those affected – people with lived experience of care – are an integral part of the Commission's work.

7.   The General Election

There will be a General Election in 2024 and this will place added political pressures on the system to deliver key health outcomes. The mainstream political parties will be developing their manifestos to put to the electorate when the time comes.

At a national and a local level, political leaders and local parliamentary candidates will be putting pressure on Integrated Care Boards and Partnerships, place-based partnerships and primary care providers including GPs, pharmacists, dentists and optometrists to tackle problems experienced by their constituents of poor access to care and treatment, varying quality of care services, workforce low pay and staff shortages, and growing health inequalities.

4 The Commission's Key Questions for 2024

1. **Lessons learnt from 2023:** What are the main lessons to be learnt from the experience of ICSs in 2023 that should inform the development of ICSs in 2024?

2. **Balancing competing demands:** How can ICSs reconcile pressure to focus on NHS priorities with their wider objectives of improving public health and their local communities and economies?

3. **Coping with funding pressures:** How can the all the partners in ICSs (NHS, Local Government and the VCFSE sector) work together to address the funding pressures they face individually and collectively?

4. **Improving the public's health:** To what extent is there support for shifting resources from treatment to prevention, improving the public's health and addressing the wider determinants of ill-health (e.g. inequality, poverty, low pay, poor housing and the environment)?

5. **Primary and community care reform:** There appears to be little appetite for further structural reform of ICSs but to what extent is change needed in primary and community care?

6. **Workforce development:** To what extent should development of the social care workforce be a priority nationally and locally alongside the implementation of the NHS workforce plan; and what needs to be done to ensure they are fully aligned?

7. **ICS governance:** What are the priorities for improving the governance of ICSs in 2024 e.g., stronger relationships between ICS Boards and ICS Partnerships, greater democratic accountability, the voice of people with lived experience of care, deeper partnerships with the VCFSE sector?

8. **Priority groups and conditions:** To what extent should ICSs give priority to particular groups or health conditions such as children and young people, people with learning disabilities, people with mental health needs and communities experiencing health inequalities?

9. **Overcoming barriers to progress:** What is the biggest national barrier to local progress of ICSs and how could it be overcome? And what is the biggest local barrier to progress and how could it be overcome? Does this Government or a future one intend to fully implement the Hewitt Review's recommendations?

10. **Support for health and social care devolution:** Could NHS England do more to bring together people and processes as well as technological leadership and investment? To what extent is there cross-party support for health devolution and further integration of the NHS with social care and public health?

5 The Commission's Focus in 2024

Against this background, the Commission will be continuing its work in 2024 to identify and spread best practice in integrated care systems, identify and explore solutions to key challenges facing systems and services, and to shine a spotlight on people or issues that might otherwise get overlooked by system leaders.

The Commission has identified three specific themes that will provide a focus for its 2024 series of roundtables namely, primary and community care reform, putting public health in the driving seat, and the impact of ICSs:

Primary and community care reform (March 2024)

In its March 2024 meeting the Commission will explore what the scope, leadership and development of integrated primary and community care should look like:

- What services should be within scope – e.g., GP practices, district nursing, dentistry, pharmacy, optometry, community mental health, allied health professionals, public health, social care?

- What different sectors should be involved – e.g., the public sector including education, housing and economic development, the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector, private health providers, and local businesses?

- Which population groups should be covered – e.g., children and young people, adults, older people, people in high health risk groups, people with learning disabilities, people who do not routinely access mainstream services?

- What shared care outcomes should they seek to achieve – e.g., national or locally determined priorities, better access to care, better experience of care, better health and care outcomes, better population health?

- Who should lead the Primary and Community Care Networks - GPs, local government leaders, VCFSE leaders, representatives of all sectors in scope?

- How is the local community involved or have a voice – ward councillors, patient reference groups, unpaid carers forums, people with lived experience of care?

- What role does the ICS and local place-based partnership play in supporting and developing the network and vice-versa: e.g., funding, planning, decision-making, structures.

Putting public health in the driving seat (July 2024)

In its July 2024 meeting the Commission will explore the idea that, over time, population health improvement goals should become the key driver of decisions about health and care resources and services. This turns the system on its head from being driven by acute care activity to being driven by people's health and wellbeing outcomes. This would put public health improvement and prevention of ill health in the driving seat of the system.

Key public health goals such as cleaner air, healthier housing, better paid jobs, better health education, healthier food, or healthier behaviours will only be achieved if all the partners – public, voluntary and private – each create services and circumstances that together contribute actively to them.

Integrated Care Systems are uniquely placed to ensure that this approach can become a reality. Effective public health and prevention may requires national action in some policy areas and but is dependant on further devolution and new ways of working in many others.

In particular the relationship between Mayors, MCAs, ICSs and place-based partnerships to create complementary and mutually reinforcing strategies for public health and prevention at different levels is key if they are to be effective.

If the General Election takes place in May, the Commission will use the July roundtable to take stock of the new political landscape and consider how best it can continue to make a contribution or seek to achieve its goals.

The impact of integrated care systems (September 2024)

By September 2024 the new system of ICSs will have been in place for 2 years and the Commission will review the impact of the changes on the issues of key concern to the Commission since its creation in 2020 including for example:

- the benefits it has brought for particular groups such as people with learning disabilities, people with mental health needs, children and young people, communities who experience health inequalities;

- delivering a 'health in all policies' and an 'economic benefit in all health policies' approach to their work;

- greater partnership working between the NHS, local government and the VCFSE sector, including democratic accountability and the voice of people with lived experience of care within its governance;

- successfully addressing the wider determinants of ill-health such as inequality, poverty, poor housing, and the environment including through new initiatives including social prescribing.

Organisations who are members of the Commission such as the NHS Confederation, the Local Government Association, professional bodies and those in the VCFSE sector such as Barnardo's and Mencap have or are planning to undertake surveys and reviews of the development, impact and performance of ICSs since they became statutory bodies in 2022. These and others will be drawn upon as the basis for the Commission's own review of ICSs at the end of 2024.

If the General Election takes place after September, the Commission will arrange a roundtable to take stock of the new political landscape and consider how best it can continue to make a contribution or seek to achieve its goals.

January 2024