

Health and Social Care Select Committee Inquiry Integrated Care Systems: Autonomy and Accountability

Sue Ryder Response
August 2022

About Sue Ryder

Sue Ryder supports people through the most difficult times of their lives. For over 65 years our doctors, nurses and carers have given people the compassion and expert care they need to help them live the best life they possibly can.

We take the time to understand what's important to people and give them choice and control over their care. This might be providing care for someone at the end of their life, in our hospices or at home. Or helping someone manage their grief when they've lost a loved one. Or providing specialist care, rehabilitation or support to someone with a neurological condition.

We want to provide more care for more people when it really matters. We see a future where our palliative and neurological care reaches more communities; where we can help more people begin to cope with bereavement; and where everyone can access the quality of care they deserve.

1. How best can a balance be struck between allowing ICSs the flexibility and autonomy they need to achieve their statutory duties, and holding them to account for doing so?

To instil accountability, all statutory duties should feature within an ICS's integrated care strategy. This includes the new legal duty on ICBs to commission palliative care services. As part of this, integrated care strategies must outline plans for the assessment of statutory requirements, which will be carried out in order to determine whether the ICS is meeting its obligations.

Any evaluation of an ICS's performance with regards to its statutory duties should be conducted independently. The Health and Care Act has introduced new powers for the CQC to have oversight of ICSs, with the CQC stating, "We expect our work to focus on assessing leadership, integration of services and care pathways, as well as quality and safety".¹ Sue Ryder believes that responsibility for assessing and reporting on the delivery of statutory requirements must also form part of the CQC's oversight role.

In doing so, the CQC should consider how best to align its regulatory responsibilities with those of other bodies such as local authority Health Overview and Scrutiny Committees (HOSCs), Health and Wellbeing Boards (HWBs) and local Healthwatch to ensure effective oversight and scrutiny.

¹<https://www.cqc.org.uk/news/stories/statement-dr-rosie-benneyworth-government%E2%80%99s-announcement-health-care-bill> (last accessed 06.08.22)

A centralised process of support should immediately be implemented for ICSs identified as failing to meet any statutory duties on completion of a CQC assessment. This process should recognise that each ICS will face unique challenges and therefore solutions to remedy the failure will need to be locally focused. The inclusion of statutory duties within integrated care strategies will prove integral to this, supporting both parties to identify the cause of the issue and where changes are required. Further, transparency around an ICS's failure to meet statutory obligations and progress against actions being taken to rectify this is absolutely necessary for accountability.

In order to strike a balance between flexibility and autonomy, a baseline level of provision and quality of care must be specified for statutory duties in the form of guidance. Guidance should set out what needs to be in place for ICSs to deliver on their responsibilities, without being prescriptive about how this is achieved. This approach will help to minimise the variations in provision that create a postcode lottery, whilst enabling each individual ICS to plan and deliver care based on local circumstances. For this to work in practice, the CQC's evaluation model must recognise and account for ICSs taking different approaches.

ICSs must conduct regular and wide-ranging conversations with providers, healthcare professionals and communities to ensure the needs of the groups they represent are both understood and met. Though ICSs must have the flexibility to determine how statutory duties are met, they should be able to demonstrate to the CQC that this engagement has taken place and underpins decision making, where required.

Issues such as workforce challenges and waiting lists are long-term, national problems faced by every ICS. It is vital that ICSs consider how to achieve their national statutory duties and meet local priorities in the context of these challenges and incorporate this within integrated care strategies.

2. What does a permissive framework for ICSs look like in practice?

NHS England must provide ICSs with a sensible, achievable framework for statutory duties in the form of guidance. Guidance should outline a 'baseline' of what provision needs to be in place to cover essential services, as well as the required outcomes of the relevant services/pathways. However, guidance should also iterate that striving for the baseline is not adequate and plans for provision should be in line with NHS and ICS aims to improve outcomes, improve experience and reduce inequality. Best practice examples should also be included to guide ICSs as to how such statutory duties and outcomes can be achieved.

This approach allows for local autonomy to solve the issues which suit the community best and enables ICSs to build on baseline provision where it is considered necessary. Though such decisions should not be dictated by centralised guidance, they must be informed by local Joint Strategic Needs Assessments (JSNAs) and aligned to Joint Local Health and Wellbeing Strategies. They should also be shaped by non-statutory national frameworks, such as the Ambitions for Palliative and End of Life Care.²

² National Palliative and End of Life Care Partnership (2021), Ambitions for Palliative and End of Life Care: A National Framework for Local Action 2021-2026.
https://acpopc.csp.org.uk/system/files/documents/2021-05/FINAL_Ambitions-for-Palliative-and-End-of-Life-Care_2nd_edition.pdf

ICSs should be afforded the permission to research, test and learn. The flexibility to think differently, innovate and trial new models or approaches is vital to understanding whether current ways of working are the right ones, and identifying changes that can deliver benefits (such as cost savings or improved outcomes). Regulators and other bodies should not be punitive where such research does not result in the desired outcome. Instead, it should be seen as an opportunity to share important learning with other ICSs.

It should be noted that, whilst it is imperative that ICSs consider and test different ways of working, certain essential services must always be delivered. For palliative and end of life care, an example of such a service would be 24/7 access to a specialist palliative care professional advice line.

3. Are central targets consistent with local autonomy in this context?

In line with our responses to previous questions, we believe that central targets can be consistent with local autonomy, so long as the correct balance is struck between the two. We have set out our view as to how the balance can be achieved throughout this response.

We would go further to say that central targets are essential in order to prevent inconsistent service provision. Sue Ryder's new research, *A Better Route Through Grief*, found that there are significant disparities in the availability of bereavement services across the country - creating a patchwork of support.³ A lack of central targets will only serve to worsen disparities in service provision across different ICSs.

We believe that changes could be introduced in order to ease the reporting burden of central targets for providers. Currently each ICS has different KPIs for providers to report to each month. This is time-consuming and resource intensive as it means that IT systems cannot be configured to capture all of the required data and integrate with ICS systems. We would welcome a core data set which is consistent across ICSs for providers to report to, allowing systems to be put in place to efficiently capture and input information. An added benefit to this change is that it would better enable both providers and central bodies to compare data and understand the wider picture.

Further, we believe that central data on national targets should be more widely and openly shared with providers.

4. To what extent is there a risk that ICBs become an additional layer of bureaucracy if central targets are not reduced as ICBs are set up?

We do not believe there is any great risk that ICBs will become an additional layer of bureaucracy if central targets are not reduced. ICBs remain important to maintaining accountability for reaching central targets, and should in turn set their own Place-based

³ Sue Ryder (2022), *A better route through grief: Support for people facing grief across the UK*. <https://www.sueryder.org/sites/default/files/2022-06/A%20better%20route%20through%20grief%20report.pdf>

targets aimed at achieving these. Although we recognise that there needs to be an intermittent review of this balance to ensure that this does not become an increased risk.

There is, however, a wider risk that the introduction of ICSs will not deliver on the intended national aims of the transformation if processes such as commissioning are not sufficiently altered and the sustainability of services improved. This structural change is a significant opportunity to deliver better, more integrated care and ensuring this happens is core to ICBs. In order for this opportunity to become a reality, recognition must be given to the inadequacy of some commissioning models that currently exist.

When considering where bureaucracy can be eased, as outlined in the previous answer, we would welcome streamlining of data requirements in order to reduce the reporting burden for providers and to create a national opportunity to better understand people's needs.

5. What can be learned from examples of existing good practice in established ICSs?

Much can be gained from examples of existing good practice, as well as lessons learnt, in established ICSs. Such learnings would likely prove beneficial to newly formed ICSs as they develop integrated care strategies. This is particularly the case for ICSs with similar characteristics to an established ICS, such as demographics or geography.

It is essential that proactive sharing of such learnings is something that is expected of and practised by all ICSs going forward. However, for this to work in reality, processes and structures that facilitate shared learning must be established. We would suggest that a shared library/platform which allows ICSs to share and access learnings is created. This should be open to contributors and examples beyond England.

We acknowledge that, in order for this to be effective, it is not enough just to provide a platform for the exchange of information. A culture of sharing best practice must be fostered and the right incentives considered at both national and ICS level to encourage ICSs to impart advice and knowledge.

Consideration must also be given as to how providers working within the same sector and ICS footprint share best practice. Whilst this may occur naturally in some circumstances, support is needed for this to happen effectively on a wider scale. Sharing best practice and encouraging the fostering of this as a way of working should be championed by NHS England and Improvements, and should be brought to life for different parts of the sector by their networks and leads. For example, in palliative care this would be through the Ambitions Partnership and in Neurological care this would be led by the National Clinical Directors for Neuroscience. These groups/individuals should take responsibility for the sharing of good practice with DHSC/NHSEI and ensure case studies are regularly updated at a national level and are available as part of core strategic planning and commissioning guidance.

Each ICS is unique in terms of local need, meaning that what works well in one area may not be the right approach elsewhere. Yet where good practice has been identified in another ICS, it can make sense to replicate this rather than spending time and resources considering solutions which may not be as effective. It is therefore integral that each ICS consults early

on with providers, stakeholders and communities when considering best practice examples for inclusion in their own strategy. Engagement with such stakeholders will support the ICS to determine whether the approach or model is the best fit for their own population.

As outlined previously within this response, it is important for each individual ICS to research and innovate in order to continuously improve outcomes, identify efficiencies and deliver care better. Learning from and adopting the best practice of other ICSs has many benefits, however it cannot be a substitute for ICSs exploring and testing ideas within their own footprint.

6. What scope is there for variation between ICSs, to enable them to improve the overall health of the populations they serve and tackle inequalities?

Variation between ICSs should be expected in order to address the different needs of Places and communities.

ICSs should be enabled and encouraged to tackle the issues which most affect their communities, and give permission for each Place to find local solutions within the ICS footprint.

In order to identify, prioritise and co-produce solutions to the issues to be addressed, ICSs must utilise data from local JSNAs and engage both extensively and meaningfully with local government, NHS and the VCSE sector.

Whilst variation is necessary to tackle the individual circumstances of each ICS, it is likely that some bordering ICSs will face the same challenges and in turn, seek similar solutions. We recommend that in such situations, ICSs look to work in partnership with neighbours to ensure a cross-boundary approach and avoid a postcode lottery of service provision. However this should only be considered for appropriate distances such as where a service is on or near the border of both ICSs.

7. How can it be ensured that quality and safety of care are at the heart of ICB priorities?

It is positive that the CQC identified quality and safety as one of the key areas of focus when commenting on their new ICS regulatory powers⁴. However, we believe that this should be taken further and formalised as part of the CQC's role.

Minimum standards relating to quality and safety should be embedded within commissioning, enabling the CQC to easily identify where an ICS is falling short.

Workforce planning must be central to such minimum standards. In order for safe, high-quality care to be provided, each ICS should develop a workforce strategy that covers their entire health and care workforce, not just NHS teams. Closer integrated working between the NHS and ICS providers, such as sharing of workforce plans/data, is also

⁴<https://www.cqc.org.uk/news/stories/statement-dr-rosie-benneyworth-government%E2%80%99s-announcement-health-care-bill> (last accessed 06.08.22)

essential. The healthcare workforce is limited and coordinated planning is required to ensure services are safe and can meet the needs of patients.

8. How best can this be done in a way that is consistent with how providers are inspected for safety and quality of care?

Regulatory and auditing frameworks should align across what service level data is collected and how the ICS, as a whole, is rated by the CQC. However, this should be reviewed to ensure a shortlist of measures which provide the ICS with an overarching view of safety and quality are collected. Such measures would include workforce figures and waiting list statistics across all health service provision.

It is crucial that providers report against safety and quality metrics to ensure standards are maintained in the delivery of care. However, as we have previously highlighted, reporting can prove an onerous process. This is not only due to the lack of consistency across different ICSs, but also a result of the number of metrics service contracts require providers to report against.

Any additional reporting requirements deemed necessary to suit the Place-based approach should therefore be considered carefully in terms of value added. We would also reiterate the need for greater alignment of metrics in the form of a core data set that is consistent across ICSs.

9. How can a focus on prevention within ICSs be ensured and maintained alongside wider pressures, such as workforce challenges and the electives backlog?

A long-term approach to prevention should remain a central focus within each ICS regardless of wider pressures. As outlined in response to question one, ICSs must account for such challenges when planning how they will meet their duties and deliver on priorities.

We believe that prevention efforts can be supported by ring-fencing funding so that it cannot be diverted to tackle immediate pressures such as workforce challenges and the electives backlog. Incentives could also be built into the system to ensure that prevention funds are protected and are truly long-term.

Prevention projects must be allocated the necessary funds to secure the longevity of the initiative. However, funding must also be flexible enough to accommodate changes over time. For example, a significant change in population health and prevention needs over a five-year period may necessitate a shift in focus.

Local knowledge such as JSNAs should inform each ICS's prevention priorities and drive where funding is best spent. Further, preventative solutions should be both co-produced and community led. For example, smoking cessation initiatives must be informed and led by smokers who want to stop and who have stopped, rather than by national targets or companies with relevant interests.

Whilst decisions around prevention must be made at a local level, there is potential value in establishing a central body or producing guidance which supports ICSs to determine their needs and solutions.

In the first instance, we recommend that it is the role of the regulator to review whether each ICS is adequately planning for, funding and carrying out prevention initiatives. Legislation may be needed in the longer-term if prevention efforts are continually insufficient.

It is not enough, however, for prevention to sit as a separate strand within an ICS's strategy. Prevention should be considered and built into everything that the ICS sets out to achieve.

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