Lancashire and South Cumbria VCFSE Alliance

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Lancashire and South Cumbria VCFSE Hewitt Response Summary

Background

VCFSE leaders across Lancashire and South Cumbria collaborated on a response to a national review into the local health system. The evidence submitted will be considered as part of the review into the Integrated Care Systems being led by Rt Hon Patricia Hewitt who has been appointed by the Secretary of State for Health and Social Care.

The review will 'consider how the oversight and governance of ICSs can best enable them to succeed, balancing greater autonomy and robust accountability'.

Despite the short time-frame, representatives of the LCS VCFSE Alliance contributed to the response. Thanks in particular for their contributions over New Year to Blackpool Citizens Advice Bureau, Age UK Lancashire, Lancaster CVS, Spring North, and Community Futures. Thanks also to Joe Hannett and to Voluntary Sector North West for pulling together responses.

Headlines

1. Local VCSE Alliances, which exist in every ICS, should be recognised in statute as a full partner of the ICB and ICS.
2. We need to fast track the VCFSE sector's potential to develop innovative models of delivery, collaboration and market mobilisation. Each ICB should be able to invest in a VCFSE Challenge Fund to help drive this forward.
3. The VCFSE role at place should be recognised, developed and supported. This means strategic voice and the implementation of a local VCFSE market development strategy.
4. The voice of people with lived experience needs to be turned up. This means enhanced roles in service design, in the measurement of impact, peer and training support, and inclusion in community based research in order to build our evidence base. Blackpool's 'Health Determinants Research Collaboration' offers us an important first step in how we could do this better.
5. Prevention, with a focus on addressing the wider determinants of health inequality, needs to be mainstreamed. ICBs and ICPs should be asked to develop a fiscal metric for their ambitions. We will always just be fire-fighting unless we increase our prioritisation of prevention and early intervention.
6. Collaborative working arrangements between NHS providers and local VCFSE should be established. We need to mobilise all local resources for improved outcomes.
7. The NHS should conduct a national review of the VCFSE role in hospital flow (discharge, admission and readmission prevention). The sector should be included as a full partner, from the start, in winter pressure planning.
8. Local VCFSE Leaders should have regulated access to local strategic health and care data in order to drive improvement in health and care outcomes.
9. The NHS's 'Embedding the VCSE in ICS Programme' should be enhanced. This should support reviews (like the sector's role in winter planning) and further develop current guidance and models of working with the sector such that the role of the sector becomes mainstream.

Summary

The VCFSE sector needs to be recognised as an equal and full partner within the system. The support needed for this is long-term commitments to funding with plans for extending work in prevention rather than a crisis response approach. With this support in place, the VCFSE sector can continue to build on excellent work that has already taken place and play its part in making the system work for all of its users.

Key quotations

'Our view is that the inclusion of the sector as a full partner is a precursor to sustainable innovation and transformation: transformation is about culture and system…'

'…establishing Place-based VCFSE groups to support the local voice of the sector…'

'…focus on lived experience/service user voice…'

'…hope for a future where we share resources, leadership and power in order to make the system better…'

'…real-time integrated working…'

'Prevention agenda has been discussed but has yet to be filtered down to action/funding…'

'…to increase innovation we need to better understand need, turn up the volume of the user's voice in service-design…'

'The VCFSE is a crucial missing partner…'

'…this is a fundamental shift in working relationships and will not be achieved overnight…'

'…how can national bodies understand the real needs of local communities/populations…'

'These developments, with VCFSE inclusion, need resourcing to realise their full potential…'

'Dealing with immediate crisis after crisis is clearly urgent, however there needs to be a investment proposition (with additional investment aligned to mainstream funding) developed by each ICS with a 5 year ambition…'

Full text of the submission to the Hewitt Review made on 9 January 2023

Review Questions	Responses
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.	
Please share examples from the health and care system, where local leaders and organisations have created transformational change to improve people's lives. 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. (250 word limit)	Since 2018/19 Lancashire and South Cumbria (LSC)'s local Voluntary, Community, Faith and Social Enterprise (VCFSE) leaders have been working to configure a model capable of engaging with the ICS on behalf of the 10,000 plus VCFSE groups operating locally. There has been significant energy and effort put into this but it has often felt stop-start and uphill. The path to being recognised as a full partner should be a given and that energy spent on driving change rather than getting to the table and getting up to speed. Our view is that the inclusion of the sector as a full partner is a precursor to sustainable innovation and transformation: transformation is about culture and system. Example 'building block' successes in LSC include: establishing Place-based VCFSE groups to support the local voice of the sector; voices of people living with health inequity included in Lancashire's Health Equality Commission (IHE); progress towards signing off a working agreement (MOU) between the sector and the ICB (thanks to senior ICB exec support); broadening VCFSE engagement, accountability and mobilisation in health and care transformation through the new LSC VCFSE Assembly; inclusion of sector reps on governance structures of the ICS (including the ICB, ICP and various committees); and the increased focus on lived experience/service user voice at ICB/ICP strategic groups. As stated, much of this should have been built in from the beginning of STPs (the precursor of ICSs). The NHS Confederation and Lord Victor Adebowale articulate how the sector is a "game-changer in ICSs": https://www.nhsconfed.org/articles/voluntary-sector-game-changer-integrated-care-systems
Do you have examples where policy frameworks, policies and support mechanisms have enabled local leaders and, in particular, ICSs to achieve their goals? This can include local, regional or national examples. (250 word limit)	1. The waiver of the Control of Patient Information (COPI) notice during Covid. This unlocked positive information sharing, supported collective decision-making and created hope for a future where we share resources, leadership and power in order to make the system better. See Data and Transparency response below. This enabled the kind of real-time integrated working with the VCFSE sector in LSC that should be the next stage goal for ICSs. Statutory inclusion of the VCFSE sector in the ICB/Provider Collaborative could be an effective mechanism to re-assert this model of working. 2. The support of the NHSE's "Embedding the VCSE in ICSs" Programme has been fundamental to sector involvement in Lancashire and South Cumbria and across England. This programme and the collective voice of VCSE Alliance leads across England also helped create the following two guidance documents (3 & 4). 3."ICS Implementation guidance on partnerships with the voluntary, community and social enterprise sector": https://www.england.nhs.uk/wp-content/uploads/2021/06/B0905-vcse-and-ics-partnerships.pdf This has been good but needs increased emphasis in terms of ICBs per se (rather than ICSs) and Provider Collaboratives. The latter especially needs further thought/direction in terms of inclusion at system and at place; the model of Provider Collaborative collaboration with and inclusion of the VCSE sector at place is especially important. This needs to be signed off by individual NHS providers too.

	4. "ICS implementation guidance on working with people and communities": https://www.england.nhs.uk/wp-content/uploads/2021/06/B0661-ics-working-with-people-and-communities.pdf Again, this needs updating: ICSs and ICBs can sign this off but this does not necessarily mean sign off at place and NHS Provider.
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? This can include local, regional or national examples. (250 word limit)	1. Since the COPI waiver expired. 2. Consideration of the local VCFSE sector as extra and not core to ICBs, Provider Collaboratives and collaborative working arrangements. 3. Short-term funding, often from central government departments which is passed to local agencies to distribute with the VCFSE, especially where it must be spent by the end of the financial year must be given more local flexibility. A strategic approach for underspends or slippage which addresses one or two fundamental issues such as early years and family support is preferable. 4. Annual budgets for NHS and Local Gov mean all thinking and planning is short term, which leads to behaviour where an invest to save model is impossible and only things with immediate operational impact are considered, which is detrimental when trying to address entrenched inequality. 5. Prevention agenda has been discussed but has yet to be filtered down to action/funding long term impact v short term funding 5 year forward planning v short term commissioning, responsibility v accountability (devolving delivery and budgets). Please see recommendation around a local fiscal metric linked to transformation (and mainstream budget) in the last two Questions (below). 6. Winter pressure planning should be done further in advance and include the VCFSE as a fundamental partner in designing and coordinating answers. As we are not automatically included at the start, we are approached at the 11th hour.
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)	1. In order to increase innovation we need to better understand need, turn up the volume of the user's voice in service-design, integrate service-user voice in the measurement of impact, devolve service delivery to a range of delivery partners, move away from measuring the numbers of people entering the front door of services, instead, ask the question why they are using this door, measure their return visits and better understand people's experiences. 2.True EDI at C-suite, development programmes for people who may have never even contemplated being in that situation - something akin to NED development for people with "lived experience" of health inequity. This needs to be much more substantial than "Patient Stories" (which are valuable, but can distract from the need to fully embed lived experience in driving system working). We need substantive, leadership roles with support and development aimed at mitigating "imposter syndrome". 3. Building on these two points, if we are going to drive innovation linked to driving change, we need to fund community-based and co-produced research as part of embedding lived experience across service design and delivery. Blackpool's *Health Determinants Research Collaboration* (HDRC), embedded within system and place delivery, is one way in which this way of working could be scaled up: https://www.nihr.ac.uk/news/50-million-awarded-to-local-government-to-tackle-interventions-for-health-inequalities-through-research/31654

	4. Set aside a VCFSE Innovation or Challenge Fund linked to commissioning for outcomes not outputs. 5. Recognise and include the local VCFSE sector as a statutory partner in ICBs and ICSs. Use the VCSE Alliance partnerships now developed in every ICS.
What policy frameworks, regulations or support mechanisms do you think could best support the active involvement of partners in integrated care systems? 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. (250 word limit)	1. The VCFSE is a crucial missing partner. It is clear that neither the state nor the market can affect the scale of change required in our Health and Care system on their own, or even between them. There should be clear statutory expectation that an ICS invests in and creates dedicated VCFSE capacity to engage in and shape ICS aims; this should be linked to developing innovative models of delivery, collaboration and market mobilisation that make better use of the sector's potential (as an integral local partner). This should be codesigned with the sector (using VCSE Alliances) and invested in over a minimum three year cycle (5 years ideally). It should be recognised that this is a fundamental shift in working relationships and will not be achieved overnight. An effective partnership with the VCFSE sector requires a firm and clear commitment from public sector partners, a shift in health and care culture (that will benefit partners, communities and citizens) and support to create a powerful VCFSE operational environment where the sector is not fighting to standstill. Specific guidance around how statutory and non-statutory services should (not can or might) work together and how investment decisions are made based on impact not organisational need. 2. The developments around Provider Collaboratives are a positive move towards there being collective responsibility for performance and quality. They also open up opportunities for the VCFSE to deliver alongside Trusts in a flexible way. These developments, with VCFSE inclusion, need resourcing to realise their full potential.
National targets and accountability	
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? (250 word limit)	1. Measure (and commission) outcomes not outputs. 2. National bodies need to be clear what is required in order for a local system to have autonomy, self-assessment has its place but delegated authority and budgets to systems not ready to handle it is avoidable by involving others - like the LGA's peer review process. How can national bodies understand the real needs of local communities/populations? These need to be identified, designed and delivered locally. There's a balance between local freedom and supporting continued siloed working. National targets need to build accountability that support the ICS partnership (as opposed to the ICB), and not undermine and make it a conduit for monitoring. The principles of Core 20 + 5 may be a mechanism for a pragmatic answer.

What mechanisms outside of national targets, for example peer support, peer review, shared learning, or the publication of data at a local level could be used to support performance improvement? Please provide any examples of existing successful or unsuccessful mechanisms	1. All of these would be useful but they need to be accessible, transparent and welcoming of diverse perspectives. JSNA/Health and Well Being Strategies have in some ways been unsuccessful as there are no associated performance measures to assess impact/achievement. Constant confliction of LG and NHS strategies which can exacerbate health inequalities (planning permission for takeaways v obesity/health eating, licenses for HMO's v improvement of housing standards). 2. The developments around Provider Collaboratives are a positive move towards there being collective responsibility for performance and quality. They also open up opportunities for the VCFSE to deliver alongside Trusts in a flexible way. These developments, with VCFSE inclusion, need resourcing to realise their full potential. 3. There are some highly effective pieces of work happening around the VCFSE role in hospital discharge and transfer of care in Lancashire and South Cumbria. However, we know that a number of ICS are exploring similar work with the VCFSE sector but that this work is being developed one system at a time. There needs to be (i) mechanisms to support the 'rapid policy transfer' of such work across England. Models of VCFSE working seem to be inordinately siloed and seen as subcontracted pieces rather than potential mainstream models. This reflects assumptions about (ii) the status of the sector as part of ICBs and nationally, and often not (iii) addressed in ICB board and ICB exec induction programmes.

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.

Do you have any examples, at a neighbourhood, place or system level, of innovative uses of data or digital services? 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. (250 word limit)	Lancashire and South Cumbria's Nexus Intelligence serves up complex data in an accessible manner. Under the COPI waiver during Covid, it was possible to configure to give a non-personally identifiable overview of the system from many different sources. The possibility for future resource deployment, integrated intelligence and integrated service development were exciting. Access to it by defined VCFSE organisations who met certain tests on data security etc. was being explored until the developers said that COPI wouldn't allow such access and all that had been possible during COVID due to the waiver was stopped. The Lancashire and South Cumbria case study ("One small team created cloud based predictive modelling solutions to improve healthcare services") and the platform are accessible via Amazon Web Services: https://aws.amazon.com/blogs/publicsector/one-small-team-created-cloud-based-predictive-modeling-solution-improve-healthcare-services-uk.
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)	UK Open Data and Open Referral data standards implemented. One single standard of reporting (with specific reference to the VCFSE sector, each funding partner requires a different set of measures and reporting). There needs to be accessible data platforms for all partners, including the VCFSE sector.
What standards and support should be provided by national bodies to support effective data use and digital services? (250 word limit)	Each ICS is inventing the wheel when it comes to including VCFSE data and intelligence and including the sector in accessing data. There needs to be a national review of how to support VCFSE (i) access to local data and (ii) how to include VCFSE intelligence in local 'dashboards'. This review should consider recommendations for capital and revenue investment (aligned to ICSs) in order to include the VCFSE sector in both aspects.

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.

What 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?	Dealing with immediate crisis after crisis is clearly urgent, however there needs to be an investment proposition (with additional investment aligned to mainstream funding) developed by each ICS with a 5 year ambition. Simple metrics measuring a shift in investment toward transformation should be agreed with the local ICP. The ICB should reporting to and be held accountable by the ICP on this metric. Clearly, early intervention and the VCFSE sector should have fundamental roles in supporting this transition. ICBs need space and encouragement to create genuine devolved, integrated and transformative ambitions but these ambitions should be reflected in a fiscal metric.
What type of support, regulation and intervention would be most appropriate for ICSs or other organisations that are experiencing performance or capability issues?	The issue of one or two trusts facing significant financial deficits is problematic and can undermine the whole ICS's delivery, integration and transformation programme. This may mean that an ICS is slowed to the speed of the slowest ship. There needs to be a way to support an ICS to drive forward transformation and partnership while building in measures to support institutions in need of mutual aid. This is fundamental to creating systems that drive effective devolved working arrangements rather than simply devolving blame for fiscal challenges.
Other	Nothing will change unless we prioritise and invest more in prevention. Until and unless prevention and early intervention is adequately funded, we will continue to get what we've got – we can head off some of the problems, but the short term approach of dealing with what's already a problem isn't and never will work.