Integrated Care – Key Findings and Recommendations. April 2021

Introduction

Integrated care systems (ICSs) are new partnerships between the organisations that meet health and care needs across an area, coordinate services and to plan in a way that improves population health and reduces inequalities between different groups[1]. ICSs plans have been developing since 2016, building partnerships between the NHS, local councils and other strategic partners including the VCSE sector. In April 2021 all parts of England began being served by an ICS. Ahead of this, in November 2020, NHSE published *Integrating care: Next steps to building strong and effective integrated care systems across England*[2] which set out plans to accelerate integrated care and proposed options for making ICSs statutory bodies.

NAVCA was commissioned by NHS England and NHS Improvement's Transformation Team to deliver a series of engagement events for local VCSE infrastructure bodies on these proposals, and by the NHSE Voluntary Partnerships Team to deliver a rapid review of the landscape of VCSE infrastructure within ICSs not yet engaged in its VCSE Leadership Programme[3].

This paper summarises key findings and recommendations identified from these pieces of work.

Key Findings

Level and scope of local VCSE infrastructure in ICSs
• On average, there are between four and five geographically focused local VCSE infrastructure organisations operating in each ICS area. • With some notable exceptions, the number of LIOs per ICS broadly correlates to the size of population served and number of lower-level local authorities within each ICS footprint. • Local infrastructure is predominantly arranged to operate on a footprint coterminous with 'place' boundaries, reaching down to neighbourhood as their recognised audience or operating area. • There is limited information readily available from which to map the full range of VCSE infrastructure operating on a thematic basis (e.g. on specific communities or issues) in each ICS.
Feedback on proposals for ICS development
• There was broad support for further strengthening plans to increase collaboration between the range of partners engaged in supporting health and care at a local level, and for reinforcing the principle of subsidiarity in these plans. • There was concern that a shift of focus to ICS could be at the deteriment of relationships and positive progress made between VCSEs and health and care partners within 'place' boundaries. Many reflected the view that ICS footprints are a purely NHS construct and do not reflect how the VCSE is organised or is able to easily engage.

[1] https://www.england.nhs.uk/integratedcare/what-is-integrated-care/
[2] https://www.england.nhs.uk/publication/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems-across-england/

- Similarly there were concerned changes could lead to existing relationships between VCSEs and local system leaders being disrupted as personnel move around in the development of these plans.
- Concerns were raised that clinical (and particularly acute) care would dictate priority setting and wider socio-economic determinants of health would not be given sufficient focus, leading to an undermining of the role of the VCS in supporting health and wellbeing.
- Many felt the legislative changes were less likely to have an impact than continuing to support development of mutual understanding between the VCSE and statutory health and care bodies, and this learning needed to be two-way.
- The plans present a narrow one-dimensional view of the sector and do not take account of the multiple roles it plays in integrated care. This was seen as a particular concern in relation to the aims of encouraging provider collaboration and networks.

Experience of engagement in integrated care structures

At neighbourhood:

- Quality of VCSE engagement with neighbourhood-level structures is primarily dictated by the level of understanding of the VCSE's role and potential amongst PCN Clinical Directors, which is not consistent. In turn, this leads to inconsistency in the levels of support and funded activity (for instance via Social Prescribing) that is delivered in collaboration.
- The impact of Covid has improved PCN engagement with the VCSE sector, driven most by collaborative practical action to support activity such as volunteering at vaccination sites.

At place:

- A high proportion of place-based LIOs report having limited or no engagement in place-based health and care partnership structures including ICPs (or equivalent) and Health and Wellbeing Boards. This the case for many who work at a county level, but also for a large number is coterminous with their 'place'.
- Where place-based engagement does exist, there is widespread concern about tokenism, and about how well understood the role, potential and limitations of the VCSE sector is among health and care partners.

At system:

- Working at system level can present challenges for LIOs who operate within a smaller footprint. New forms of collaboration and relationships need to be formed, and concern around losing existing relationships is high. This is seen as a strain on the limited capacity of LIOs especially given the fact that, despite system expectations, very few are funded to engage with these new structures.
- LIOs in ICS areas that have been involved in the VCSE Leadership Programme are far more likely to be directly involved in system level partnerships, and have a more positive view of their engagement.
- Where LIOs are required to work across more than on ICS they find significant variance in approach and commitment to engage the VCSE which is a further strain on limited resource.

VCSE sector collaboration for strategic representation, leadership, coordination, and service delivery

- The lack of consistent approach to funding the VCSE sector's role in integrated care structures, coupled with the high demand on LIOs, is leading to inconsistency and reducing effectiveness.
- LIOs report concerns about local health partners failing to fully understand the role, potential and limitations of the VCSE sector and, in particular to make a clear distinction between the separate roles of the VCSE as; a voice for users; a point of representation and information on the VCSE sector generally; as a service provider.

- The vast majority of LIOs are collaborating with one another to support their engagement in health at place and system, mainly via informal networks and leadership groupings to share information, experiences and best practice. There is a very varied picture in terms of how effective LIOs view this collaboration and some LIOs recognise the need to improve this themselves.
- Where engagement is working well, it tends to be built around long-standing relationships and trust between individual leaders, rather than the result of system structures.
- Only half of LIOs in all ICS areas are aware of local VCSE service delivery alliances/collaboration within their local sector, but around a third of LIOs who are aware of them are directly involved. There is little difference in the level of LIOs awareness or involvement in service delivery collaboration between ICS areas that have been involved in the VCSE Leadership Programme, and those that have not.

Recommendations

Sharing information and experiences

1. Continue to build on the successes in engaging PCNs and the VCSE by sharing examples of successful practical working generated through the pandemic, and the impact they have achieved.
2. The Leadership Programme should continue to support VCSE collaboration at system level to help provide effective mechanisms for system engagement. Continue to work with NAVCA and its members to identify priority areas for engagement based on intelligence and feedback from the VCSE sector as well as health and care system leaders.
3. A more in-depth review of local infrastructure, including thematic and issues specific VCSE infrastructure organisations should take place to give a fuller understanding of the prevalence and role in ICS areas.
4. NAVCA should work closely with NHSE and the VCSE Leadership Programme to provide opportunities for VCSE infrastructure organisations and system partners to engage with one another on a relevant geographic basis, to share experiences and learning and build greater collaboration.

Creating relationships, trust and understanding

5. Increase the systematic support to aid collaboration between VCSEs at place to ensure effective representation and that the experience of a wide variety of VCSE organisations is drawn on. Make it more focused on their experience and the individual characteristics of the VCSE sector at the individual system and place level.
6. Address concerns about tokenistic engagement by clarifying the distinct roles the sector plays, and supporting collaborative mechanisms within the VCSE, and between the VCSE and health systems, which can provide effective engagement to deliver each.
7. Further development of ICSs should not be at the detriment of the important role of the VCSE sector at place. Guidance and support should be provide to make them actively engage the sector in systems in order to avoid making their involvement in place-based partnerships more difficult. Guidance and support to ICSs should to stress the importance of place-based partnerships and give ICS's a clear and active responsibility for supporting the VCSE's engagement as an equal partner at both place and system level.
8. Leadership Programme and NAVCA should provide support and guidance to help VCSEs organisations and health system partners to identify ways to ensure representation at each level is open and transparent to avoid real or perceived competition within the sector, and to help distinguish between the sector representation, user voice and service provider roles.

Supporting Workforce Development

9. Engage local VCSE infrastructure to provide learning opportunities for PCNs to better understand the role, impact, opportunities and limitations of VCSE infrastructure in supporting population health.
10. Work with local infrastructure and other VCSEs to provide opportunities for workforce development within health and care system partners at a middle-management and below; support opportunities for learning about the local VCSE sector and build greater knowledge about, and appetite for, coproduction with the sector.
11. Be clear about how existing structures, such as Health and Wellbeing Boards will work alongside new place-based partnership mechanisms, and where and how the VCSE should focus its limited resource in order to have effective role and support local outcomes.

Providing Funding and Resources

12. Support/direct systems to resource the role they are aiming the VCSE to play at system and place in order to reduce the inconsistency that is currently prevalent. Be clear on the support provided to deliver a strategic influence, intelligence gathering and sharing, representation and leadership role, as distinct from direct service delivery, to address issues of real or perceived competition. The support provided by the Leadership Programme (e.g. to fund a sector-based ICS engagement post) is helpful and should continue, but it does not provide a long-term solution.

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