**Hewitt Review of Integrated Care Systems –
Informing the RCSLT response to the call for evidence**

Empowering local leaders

Q1 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.

> RCSLT members suggest it is too early in the implementation of ICSs to see impact, but the potential is being acknowledged. There is a desire to see examples from other ICS/Bs to share good practice.
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> One example has been provided by a service manager who has created a health inequalities partnership board which brings together a range of stakeholders to address known health inequalities for people with a Learning Disability based on LeDeR (a service improvement programme for people with a learning disability and autistic people). This has the potential to be transformational in the future.
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> The RCSLT has collected case studies of services that have created transformational change to improve lives.
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> This case study examines how support is provided to a non-English speaking family, with consideration of their cultural beliefs around mental health:
> https://www.rcslt.org/learning/diversity-inclusion-and-anti-racism/addressing-health-inequalities/health-inequalities-case-studies/#section-1
>
> This case study shows how it has been possible to support people with learning disabilities to be able to access and implement public health information:
> https://www.rcslt.org/learning/diversity-inclusion-and-anti-racism/addressing-health-inequalities/health-inequalities-case-studies/#section-2

Q2 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.

> RCSLT are calling for all ICS/Bs to support services in addressing health inequalities and unmet needs in their areas. The RCSLT health inequalities resource and audit tool (https://www.rcslt.org/learning/diversity-inclusion-and-anti-racism/addressing-health-inequalities/) has been produced to support speech and language therapists to address health inequalities in their practice. This approach needs to be repeated across ICSs and ICBs in order to have meaningful impact.
> RCSLT are calling for outcomes measurement to be central to driving improvements to care. The RCSLT Online Outcome Tool (ROOT) supports speech and language therapists to analyse therapy outcomes and monitor performance and unwarranted variation in care. This data can be used to evaluate and improve healthcare quality and outcomes, tackle inequalities and inform cost effectiveness.
> The new duties in the Health and Care Act requiring ICBs to specifically consider the needs of children and young people have considerable potential, if implemented meaningfully, to enable ICSs to achieve their goals. The accountability system must hold ICSs, both ICBs and ICPs, to account for their progress in delivering improved outcomes for children, including oversight of spending decisions and performance indicators.

The NHS guidance 'Allied health professionals within integrated care systems' also has the potential to support local leaders to achieve their goals. However, it is unclear how ICSs will be held to account for the involvement of AHPs and AHP faculties within ICS structures. We are seeing a mixed picture of involvement so far – AHPs form a third of the NHS workforce and need to be included.

Q3 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.

RCSLT members say that the change to ICSs is being 'felt' in the ways that partners work together in new collaboratives. More is falling on providers in terms of strategic roles and funding decisions. This is a complex culture change to work through practically and is slowing down some decisions.

We are hearing of unrealistic expectations about implementation at pace or bidding for funds. Innovation needs sufficient time and stimulation of fresh thought to deliver for the long term. NHSE policy is not matching reality on the ground.

As an Allied Health Profession (AHP), difficulties are being felt by speech and language therapy services because there is no mandatory AHP representation on ICBs. There is in many cases no seat at the table to represent the roles of one third of the NHS workforce.

A lack of workforce planning, national assessment of demand and unmet need has led to SLT becoming a shortage profession, with huge waiting lists for children and adult services. Workforce planning at local levels fails to take account of SLTs employed by non-health employers, such as those working in independent practice, schools; and employed by the NHS but working in non-health settings.

Accessing individual ICS/B leads in a timely and coordinated manner has potentially compromised the agility and access to engage /support them as they develop. Having a centralised directory would be optimal

Fragmented services and lack of funding across care pathways add delay, duplication, and unwarranted variation eg adult rehabilitation services, child to adult transition services.

Q4 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?

RCSLT members have said that with the power moving to collaboratives of providers and partners (due to CCGs ceasing), more is falling on providers in terms of strategic roles and funding decisions. This is complex to work through practically and is a culture change; this change in governance and decision making is slowing down some decisions.

There are many ideas for innovation but delivery is complex as the governance and systems are newly set up and being trialled.

ICSs still feel very new. They need time to bed down before there is any chance of increasing innovation. The top-down expectation for this is unrealistic and could have the opposite effect, impacting adversely on morale, engagement and retention.

Q5 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.

> Guidance from DHSC/NHSE should make clear that education and early years partners must be represented in ICSs. Early years and childcare providers, schools and colleges are vital partners in health and wellbeing for children and young people, and without their strategic involvement and participation it will not be possible for ICSs to achieve their aims when it comes to children and young people – who represent around 30% of the entire population. Within ICSs the voices of the children's workforce across the NHS, local government, voluntary and community sector (VCS) and education settings must be represented through strong leadership at the highest levels of decision making in every ICS.
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> In this case study we show how the introduction of 'Case Coordination' meetings' for active involvement of partners through new care pathway in youth offending setting, facilitated better outcomes for children and staff: https://www.rcslt.org/learning/diversity-inclusion-and-anti-racism/addressing-health-inequalities/health-inequalities-case-studies/#section-6

National targets and accountability

Q6 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?

> RCSLT would like to see the following:
> - Focus on outcomes not inputs
> - More transparency on waiting lists;
> - Consideration of the evidence about how investment in targeted level therapies reduces demand for specialist interventions;
> - Meaningful discussion with people in touch with frontline health and social care;
>
> In addition, it's important to ensure targets do not skew service delivery and result in unintended negative consequences. One example of this is the current target for waiting times from referral to treatment (RTT). For speech and language therapy, in reality this is the waiting time from referral to first appointment. In some areas, the focus on this target is leading services to reduce the treatment that they offer following that first appointment, meaning that in some cases children only receive an assessment of their needs, and no further support or intervention is available. This does not deliver good outcomes for children, nor does it support ICSs to improve outcomes in population health, reduce inequalities and support broader social and economic development.

Q7 What **mechanisms outside of national targets** could be used to support performance improvement? Examples could include peer support, peer review, shared learning and the publication of data at a local level. Please provide any examples of existing successful or unsuccessful mechanisms.

Performance improvement should be driven through supportive mechanisms such as peer support and peer review.

One example of a peer review programme which could be replicated is the Early years social mobility peer review programme. This programme was funded by the Department for Education and delivered by the Local Government Association. Importantly, peer reviewers were seen by local authorities as critical friends who brought professional expertise, but also an understanding of the challenging context in which councils operate. Peer reviewers were recruited from a range of disciplines, including speech and language therapy - the range of expertise in the peer review teams was seen as a major strength of the programme, with the vast majority of councils 'very' or 'somewhat satisfied' with the expertise of the team leader (88%) and of the team members (96%).
An external evaluation of the peer review programme by Ecorys found that 96% of participating councils had implemented some, most or all, of the recommendations received. More information about the programme can be found at the links below

https://www.gov.uk/government/publications/early-years-social-mobility-peer-review-programme

https://www.local.gov.uk/about/news/local-government-early-years-peer-review-programme-hailed-independent-evaluation

Data and transparency

Q8: 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.

Data on impact of services

The RCSLT online outcome tool (ROOT) contains data on nearly 70,000 patients receiving speech and language therapy. This data is used centrally (by RCSLT) and locally (by services) to evaluate the outcomes, quality and experiences of services and drive quality improvements. See case studies from SLTs using data innovatively to improve services and outcomes:

https://www.rcslt.org/members/delivering-quality-services/outcome-measurement/outcome-measurement-influencing-and-campaigning/#section-3

It is important that there be a fully accurate dataset for all staff in all professions in the ICS, including those providing NHS services outside the NHS (eg in justice and education)

Local example of innovative use of data

One NHS Trust employs a Place Based Intelligence & Performance Lead whose role is to provide services with current operational data to analyse child-level information related to pathway waits. This has led to improvements in more timely delivery of care and the avoidance or reduction of harm while children are waiting. As a result the service is able to use data to effectively prioritise the waiting list to target those at greatest risk, for example, those with known vulnerabilities or those children in neighbourhood areas with the highest levels of deprivation.

Q9: 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?

A universal patient record systems/IT systems or at a minimum a core data set would help to improve data collection. It could also be helpful for regional ICS data to be shared so different ICSs can compare and learn from others' practice.

In addition, the adoption of a national consistent child identifier (CCI) would be an important step forward to improving data collection and information sharing for children and young people. In response to the work of the CYP Health Policy Influencing Group and members of the House of Lords during the passage of the Health and Care Bill, the government acknowledged the serious challenges with sharing relevant information about children. It has equally recognised the potential benefits of a single consistent identifier that would bring together disparate records about an individual child.

To address this, an amendment was made to the Act that requires the government to lay a report before Parliament within a year setting out:
- The Government's policy on a consistent identifier for children and its approach to improving information sharing more generally;
- How this can be achieved across health, children's social care, police, and education settings; and
- The cross-government actions that will be taken to implement the policy set out in the report.

It will be important that this report results in government action to implement a CCI.

Q10: What standards and support should be provided by national bodies to support effective data use and digital services?

Consistent and accessible data across health, social care, education and private providers to ensure secure timely patient data - this is evolving but going faster would directly benefit service delivery.

The adoption of a national consistent child identifier (CCI) would be an important step forward to support effective data use with regards to children and young people. In response to the work of the CYP Health Policy Influencing Group and members of the House of Lords during the passage of the Health and Care Bill, the government acknowledged the serious challenges with sharing relevant information about children. It has equally recognised the potential benefits of a single consistent identifier that would bring together disparate records about an individual child.

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System oversight

Q11: What do think are the most important things for NHS England, the CQC and DHSC to monitor, to allow them to **identify performance or capability issues and variation within an ICS that require support**?

RCSLT wish to see the following:
- Fundamentally, performance should be about outcomes and impact of services on citizens, not inputs.
- Data on the demand for services (e.g. referrals) should be collected, not just the performance on inputs achieved.
- The amount of capacity in the workforce, in relation to the demand/population need, must also be considered.
- Metrics based on qualitative patient experience not just data driven. The patient voice must be central to understanding whether services are appropriately targeted and delivered.

It is crucial that NHS England, the CQC and DHSC also understand and monitor unmet needs and how ICBs are tackling health inequalities – The RCSLT's recent webinar provides examples of how local services are considering unmet need in order to address health inequalities https://www.rcslt.org/events/health-inequalities-webinar/#section-1

Q12: What type of **support, regulation and intervention** do you think would be most appropriate for ICSs or other organisations that are experiencing performance or capability issues?

Any intervention should be supportive, helpful and compassionate. Expectations of ICSs must be realistic given current challenges within the system, and the short amount of time that ICSs have had to become established.

As mentioned in our answer to question 7, peer support and peer review are the most appropriate mechanisms to provide support for organisations experiencing performance issues. It may be most helpful for peer support to be provided by leaders in ICSs with similar demographics. Comparisons between ICSs are unlikely to be helpful as performance needs the context of local conditions.

However, it is important that ICSs are monitored to ensure they deliver on the duties set out in the legislation – including being held to account on their progress in delivering improved outcomes for children and young people.

The new Local Area SEND Inspection Framework could be considered as an example of good practice in monitoring performance, with its greater focus on hearing directly from children and young people with special educational needs and disabilities (SEND), and their families.

Additional evidence

Is there any additional evidence you would like the review to consider?

It is imperative that any potential recommendations of the Hewitt Review build on, rather than undermine, the emphasis the Health and Social Care Act placed on babies, children, and young people within the ICS statutory framework. We believe Integrated Care Systems can present an opportunity to deliver greater collaboration within and beyond the health and care system, however we cannot expect a system which has been designed with the needs of adults in mind to work effectively for children without explicit requirements to do so.