Report to HEALTH AND WELLBEING BOARD

NHS WHITE PAPER BRIEFING: *INTEGRATION AND INNOVATION: WORKING TOGETHER TO IMPROVE HEALTH & SOCIAL CARE FOR ALL*

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Purpose of the Report

This report has been produced to provide a briefing for members of the Health & Wellbeing Board on the recently published NHS White Paper entitled Integration and Innovation: Working Together to Improve Health & Social Care for All.

Requirement from the Health and Wellbeing Board

The Board is asked to note the briefing.

NHS White Paper Briefing: *Integration and Innovation: Working Together to Improve Health & Social Care for All*

Introduction

1 The origins of the white paper were in 2019, when the Secretary of State for Health and Social Care Matt Hancock asked NHS England to identify and consult on what legislative changes were needed to fulfil the ambitions of the ten-year NHS long term plan. So, the white paper was expected at some stage.

2 The white paper does not cover broader social care reform – it gives a commitment that proposals for reform will be published this year – but it does give some direction of travel for adult social care and also for changes in public health.

3 The proposals in the white paper are considered in the following themes:

i. Working together to integrate care – statutory Integrated Care Systems (ICSs) with "dual structure" governance arrangements (the main focus of this policy briefing).

ii. Reducing bureaucracy – removing requirements on competition and procurement in the NHS.

iii. Improving accountability and enhancing public confidence – the formal merger of NHS England and NHS Improvement and new powers for the Secretary of State (SoS).

4 Additional proposals – many related to public health and adult social care. Proposals will be set out in a Health and Care Bill, with legislation in place for implementation in 2022.

Working together to integrate care

5 The white paper proposes that the forthcoming Health and Care Bill will support two forms of integration.

i. ***Removing barriers within the NHS and making "working together an organising principle".*** NHS bodies (NHSE, ICSs and providers) will have a "triple-aim" duty of better health and wellbeing for everyone, better quality of health services for all individuals, and sustainable use of NHS resources. The intention is to help align NHS bodies around a common set of objectives with strong engagement with local communities.

ii. ***Greater collaboration between the NHS and local government*** as well as wider delivery partners to improve health and wellbeing outcomes for local people. There will be a broad "duty to collaborate" across the healthcare, public health and social care system applied to NHS organisations (ICSs and providers) and local authorities. This aims to rebalance duties which focus on the role of individual organisations and their interests. Local authorities and NHS

bodies will be expected to work together in the ICS under one system umbrella. The Secretary of State will have powers to issue guidance on how the duty may work in practice.

6 ICSs will be put on a statutory footing to allow stronger and streamlined decision making and accountability. ICSs will have "dual structure" arrangements which reflect the two forms of integration – an ICS NHS body (board) and an ICS Health and Care Partnership.

7 **The ICS NHS body** will be responsible for the daily running of the ICS. Responsibilities will include developing a plan to meet health needs of the population, setting out the strategic direction for the system, "explaining" the plans for capital and revenue spending of NHS providers in the system, securing the provision of health services to meet the needs of the system population, and achieving system financial balance. The ICS NHS body will take over the functions and funding of CCGs (Clinical Commissioning Groups) and will be able to delegate funding "significantly" to place level and to provider collaboratives. It will take over CCGs' responsibilities in relation to overview and scrutiny committees.

8 NHS trusts and foundation trusts will remain separate statutory bodies and the ICS NHS body will not have the power to direct providers. But there will be a new duty to have regard to the system financial objectives so both providers and ICS NHS bodies will have a mutual interest in financial control at the system level.

9 Each ICS NHS body will have a unitary board accountable for NHS spend and performance within the system. It will, as a minimum, have a chair and a CEO and will include representatives from NHS trusts, general practice, local authorities and others determined locally, such as mental health trusts, plus non-executive directors.

10 NHSE will publish guidance on how boards should be constituted. There will be a more clearly defined role for social care in the structure of ICS NHS boards to give adult social care a greater voice in NHS planning and allocation.

11 **The ICS Health and Care Partnership** will bring together the NHS, local government and wider partners, such as the voluntary and community sector and Healthwatch, to "develop a plan to address the system's health, public health and social care needs" and to promote partnership arrangements. The ICS NHS body and local authorities will have to have regard to that plan when making decisions.

12 The Health and Care Partnership cannot impose arrangements that are binding on local government and the NHS "given this would cut across existing local authority and NHS accountabilities". Membership and functions will be determined locally.

13 The white paper suggests that the Partnership could be used as a forum for agreeing on priorities, coordinated action and aligned funding on key issues, which may be particularly useful in the early stages of ICS formation. Guidance will be published to support ICS partnerships to align operating practices and culture to "deliver for the adult social care sector".

14 The white paper stresses that within the dual structure there will be local flexibility over how ICSs are arranged, and partners are encouraged to develop mature joint arrangements that deepen integration and improve outcomes.

15 There will be new legislation to make it easier for organisations to work closely together through setting up joint committees which could either be between ICSs and NHS providers or between NHS providers. Both types of joint committee could include representation from other bodies such as primary care networks, GP practices, community health providers, local authorities and the voluntary sector.

16 The white paper makes many references to the “primacy of place”. ICSs must “support place based joint working”, with place-based arrangements “at the core of integration”. Place-level commissioning will “frequently” align geographically to a local authority boundary, and the Better Care Fund (BCF) will be a tool for agreeing on priorities. ICSs will work closely with health and wellbeing boards (HWBs) as they have “the experience as place-based planners”. The ICS NHS body will be required to have regard to joint strategic needs assessments and joint health and wellbeing strategies produced at HWB level (and “vice versa”, presumably this means HWBs will need to have regard to the ICS partnership plan). ICSs will need to consider how they can align allocation and functions with places, such as using joint committees, but models will be for local determination. NHSE and other bodies will provide support and guidance based on insights from early wave ICSs.

17 The Department for Health Social Care (DHSC) will explore how to enhance the role of the Care Quality Commission (CQC) in reviewing system working. It wants to strengthen the patient voice at place and system levels to create “genuine coproduction”.

18 Other legislative proposals include:

i. A reserve power to set a capital spending limit on foundation trusts, if needed, to support the third aim of the Triple Aim duty in relation to the sustainable use of NHS resources.

ii. Collaborative commissioning – for instance, NHSE delegating commissioning to more than one ICS board, ICSs collaborating on delegated commissioning, groups of ICSs using joint and lead commissioner arrangements to make decisions and pool funds across all their functions, and a greater range of delegated options for NHS England public health responsibilities, such as national immunisation programmes.

iii. A specific power to issue guidance on joint appointments between NHS bodies, NHS bodies and local authorities, and NHS bodies and combined authorities.

iv. More effective data sharing to support integration and digital transformation of care pathways – to be set out in the forthcoming data strategy for health and care.

v. NHS decision-making bodies will be required to protect promote and facilitate patient choice with respect to services or treatment.

Reducing bureaucracy

19 The requirement for competition applied to the NHS through the Health and Social Care Act 2012 will be removed. The NHS will no longer be subject to the Competition and Markets Authority. Where there is no value in running a competitive procurement process, these can be arranged with the most appropriate provider.

20 NHSE will consult on a "bespoke health services provider selection regime" which will enable collaboration and collective decision making. The division between funding-decisions and provision of care will be maintained. The NHS will have greater discretion over procurement.

21 The SoS will have the power to create new trusts within an ICS where this would result in the best health outcomes. Subject to engagement and consultation, ICSs may apply to the SoS to set up a new trust.

Improving accountability and enhancing public confidence

22 The merger of NHS England and NHS Improvement will be put on a statutory footing, with the organisation called NHS England.

23 The government will have new powers over the NHS to support greater collaboration, information sharing, aligned responsibility, and future agility in responding to change. These include:

i. Reforms to make the government's mandate to the NHS more flexible (the current mandate sets annual priorities and expectations for NHSE).

ii. Power to transfer functions between arm's length bodies (no plans currently other than those already underway – the NHS England/Improvement merger and establishing the National Institute for Health Protection (NIHP) and related reforms to the public health system).

iii. Removal of time limits on special health authorities (such as NHS Blood and Transplant) which currently must be renewed every three years.

24 Also, since contested reconfigurations are often lengthy and ministers have to account for decisions in parliament without being meaningfully engaged in the process, the SoS will have the power to intervene at any point in the reconfiguration process. The SoS will have to seek appropriate advice to inform their decision and publish it transparently. Statutory guidance will be issued on the new process, including removing the current local authority referral process "to avoid creating any conflicts of interest". The Independent Reconfiguration Panel is expected to be replaced by new arrangements which will be based on learning from the work of the IRP.

25 Additional measures

i. Additional proposals have emerged from work on the pandemic and will support health and care system recovery. They are designed to address specific problems or barriers rather than providing comprehensive reform.

Social care

26 The government recognises the significant pressures faced by the sector and will bring forward proposals for reform this year, aimed at ensuring everyone can access affordable, high quality, joined-up and sustainable adult social care.

27 A new improved level of accountability will be introduced within social care, with an "enhanced assurance framework" allowing greater oversight over local authority delivery of care to raise standards and reduce variation in quality. The framework will involve improved data collection to allow for better understanding of capacity and risk, for example, better data on services provided to self-funders. The Health and Care Bill will introduce a new duty for the CQC to assess local authorities' delivery of adult social care duties, and the SoS will have a new power to intervene if it is considered a local authority is failing to meet their duties. The DHSC will work with the sector on the assurance framework which will be introduced over time. There will be a new standalone legal basis for the better care fund (BCF) separating it from the NHS mandate setting process – a technical change with no impact on the BCF policy.

28 The current requirement to assess people before hospital discharge will be replaced by a Discharge to Assess model in which an individual can receive NHS continuing health care (CHC) and NHS funded nursing care (FNC) assessments and Care Act assessments after they have been discharged. This will allow assessments in a familiar environment, enabling a more person-centred evaluation of care needs. The new model will not change eligibility thresholds for CHC or the Care Act; the white paper says it will not increase financial burdens on local authorities. The system of discharge notices and financial penalties will no longer be required.

29 The SoS will have a new legal power to make payments directly to social care providers in exceptional circumstances, such as in maintaining the stability of the market (correcting a limitation in existing legislation).

Public health

30 The experience of the pandemic has underlined the importance of a population health approach and robust health protection. The government will publish proposals for the future of the public health system – the new NIHP and the remaining functions from the closure of Public Health England "in due course".

31 The proposals in the white paper will address targeted issues that need primary legislation. There will be a public health power of direction through which the SoS can require NHSE to discharge public health functions and direct how the delegated functions are exercised – effectively strengthening existing powers.

32 Legislative changes will support the rollout of the national obesity strategy; specifically, introducing further restrictions on the advertising of high-fat salt and sugar foods before 9 pm and a new power for ministers to alter certain food and alcohol labelling requirements to make healthy choices easier.

33 The white paper says that water fluoridation is clinically proven to improve oral health. Currently, ten per cent of the population of England receives fluoridated water. Councils have the power to propose and consult on new fluoridation schemes and the SoS has responsibility for approving these. In light of difficulties identified by local authorities, the white paper proposes that the DHSC would take responsibility for proposing new schemes and the associated costs; schemes would continue to be subject to public consultation.

34 Other additional proposals relate to safety and quality, such as changes to regulatory bodies including a statutory NHS Health Services Safety Investigations body and Medical Examiners System and standards for hospital food.

Some Discussion Points

35 There is a lot of detail in the white paper, and, while some of its proposals are controversial, such as powers of the SoS to intervene earlier in reconfigurations and changes to overview and scrutiny and the Independent Reconfiguration Panel, it provides a coherent set of proposals. The DHSC has listened to concerns from local government and CCGs on the central importance of place, and on making sure that ICSs reflect a broad range of stakeholders, including local government. There is much to welcome in the document on that basis.

36 With measures in the Health and Care Act 2012 under review, it would have been possible for health and wellbeing boards to have been abolished but their value has been recognised and all HWBs now need to up their game to the level of the best. The proposals give a mainstream role for local government in ICSs – boards and partnerships. This needs to be maintained in the subsequent legislation and guidance.

37 How the ICS body/board and the partnership work together will be crucial and there is much to do to get the system level working effectively everywhere, as well as the vital issue of establishing place-based arrangements. Statutory joint committees with real control over resources, bringing together providers, primary care networks, local government and voluntary and community sector representatives should be a positive way forward. These would work alongside health and wellbeing boards to establish the broad vision and priorities, promote collaboration and focus on the social determinants of health. CCGs became a valued part of the health and care landscape in many areas and their important contribution needs to be maintained.

38 The white paper describes the “shift away from an adversarial and transactional system centred on contracting and activity payments to one that is far more collaborative and dedicated to tackling shared problems”. It will probably take some time for some partners to adjust to a collaborative culture.

39 There are also some unclear areas – this is a rolling back of competition rather than a whole scale dismantling of the commissioner/provider split in the NHS. The white paper says that funding decisions will be separate from provision, but it is not clear how this will happen with providers as board members.

40 A new assessment framework for adult social care is advocated. Hopefully, a system involving both sector-led improvements with light-touch national oversight will evolve. The ultimate aim must be for assessment of integration – the CQC local system reviews of 2019 proved very informative.

41 The document does not give many clues about the future of the remaining PHE functions and how NIHP will operate. On public health it says, “rather than containing health improvement expertise within a single organisation, driving change in future will mean we need many different organisations to have the capacity and responsibility for improving health and preventing ill health”. It would have been helpful to have more emphasis on the role of ICSs in prevention and, particularly, in tackling the social determinants of health.

Conclusions

42 The white paper has been influenced by the extensive collaboration and innovation that partners from all sectors have demonstrated in tackling the pandemic. It shows a good understanding of how health, social care and public health fit together, while stakeholders’ concerns, such as ICSs potentially undermining effective place-based arrangements, have been listened to.

43 Overall, this white paper is a positive development. The lack of information on social care reform remains a huge gap, and the proposals will need to be carefully worked on. It also doesn’t seem to address the huge issues around health inequalities. ICSs have changed a lot since they were set up as sustainability and transformation partnerships and it is doubtful that this will be the last word.