Health and social care integration white paper

The government published the health and social care integration white paper, *Joining up care for people, places and populations*, on 9 February 2022. This briefing summarises its proposals for a single accountable person, shared outcomes, and increasingly pooled NHS and social care budgets at place level. It also sets out our initial analysis of the implications for trusts. Please contact senior policy manager Georgia Butterworth if you have any comments or questions.

Key points

- The integration white paper sets out the government's ambition to accelerate the delivery of joined-up health and social care at place level[1], as a way of improving health and care outcomes, and making best use of public resources. Each place is expected to have:
  - a single person accountable for delivering shared outcomes at place level by Spring 2023. They could be an individual with a dual role across health and care, or an individual lead for a place-based governance arrangement, such as a "place board".
  - a "significant and, in many cases, growing proportion of health and care activity and spend" overseen and funded through the place-based partnership. The government will develop guidance to support aligned/pooled budgets, and review section 75 regulations which enable transfers, or pooling, of funding between NHS commissioners and local authorities.
- The government will work with stakeholders to develop and introduce a framework with a focused set of national priority outcomes and an approach to support places/integrated care systems (ICSs) to identify additional local priorities. These shared outcomes will align with and sit alongside wider regulatory frameworks, and will go live in April 2023.
- In parallel, oversight arrangements will have a clear focus on the planning and delivery of shared outcomes at place level. Full details are not given, however the Care Quality Commission (CQC) will consider agreed outcomes at place level as part of its assessment of ICSs.
- The white paper explores other enablers of integration, including workforce, digital and data. It commits to strengthening ICS and place workforce planning, and states a new deadline of 2024 for

[1] In each of the 42 integrated care systems, place-level partnerships are developing at sub-system level, often arranged around local authority boundaries or other geographic footprints that make sense locally. These place-based partnerships bring together trusts, local authorities and wider partners to collaboratively plan and deliver services.

ICSs to be operating with a shared care record (previously March 2023). There will be a support offer to help all providers reach a minimum level of digital maturity.

- Taking a long-term view, the white paper sets out a complex set of proposals that could have far-reaching implications on the health and care sector, and therefore need to be worked through carefully with the health and care sector before being taken forward. We will continue to engage with government officials to work through the detail of these proposals and gather member views in response to the questions around implementation.

Summary

Shared outcomes

Following the publication of this white paper, the government will work with stakeholders to develop a framework with a focused set of national priority outcomes and an approach which places can use to develop and agree additional local priority outcomes. Implementation of shared outcomes will begin from April 2023, and there will be mandatory reporting against them. The white paper sets out some design principles for local shared outcomes frameworks, and commits to reviewing alignment with other national priority setting exercises and outcomes frameworks across the health and social care system. The government will continue to set its Mandate for NHS England. The CQC will have a role in considering outcomes agreed at place level, as part of its new duty in the bill (if passed into law) to assess ICSs.

Governance: The single accountable person

The government expects all places to have "a single person, accountable for shared outcomes" by Spring 2023. This person will be agreed by the relevant local authority/authorities and the integrated care board (ICB) and could be an individual with a dual role across health and care or an individual lead for a place-based governance arrangement. Local authority and NHS accountabilities remain unchanged. While the paper does not prescribe specific governance models, it does suggest one illustrative place board model, as well as criteria that place-based arrangements must meet by Spring 2023 (if not using the place board model illustrated in the paper). These include developing a shared plan, delivering against shared outcomes (underpinned by pooled and aligned resources), and mechanisms to manage risks and resolve disagreements. These arrangements should, as a starting point, make use of existing structures, such as health and wellbeing boards.

Health and social care budget pooling

Places are also expected to accelerate the routine pooling and alignment of "a significant and in many cases growing proportion" of NHS and social care budgets. Places will need to develop ambitious plans to increase the scope and proportion of health and care activity and spend to be overseen by and funded through 'place-based' arrangements, with a target of 2026 for "inclusion of services and spend" at place level. While the paper states that "eventually" pooled budgets and aligned financial arrangements will cover much health and care funding at place level, the government will not "at this stage point mandate how this is achieved". Later this year, the government will set out the policy framework for the Better Care Fund from 2023, including how the programme will support the implementation of integration at place level, it will also review regulations underpinning section 75 arrangements and publish revised guidance.

Leadership

The government will develop a national leadership programme, addressing the skills required to deliver effective system transformation, subject to the outcomes of the health and social care leadership review led by Sir Gordon Messenger. The white paper articulates what effective local leadership looks like, including bringing partners around a common agenda even when it runs counter to organisational interests and deciding when organisational boundaries need to be challenged.

Digital and data

The document reiterates an 'ICS first' approach to digital integration and transformation, and aims to maintain the pace of digital transformation achieved during the early phases of the pandemic. This includes encouraging organisations within an ICS to use the same digital systems to improve interoperability and provide care teams with an individual's information across a whole pathway. Where necessary, the government will intervene with ICSs and vendors by setting conditions of funding, producing guidance, and providing support. This will enable ICSs to provide support to place-based partnerships. A final version of the draft data strategy for health and care' will be published in "winter 2021/22".

The white paper sets a new ambition for each organisation in an ICS to have a base level of digital capabilities (as defined by the "what good looks like" framework). It also reiterates existing expectations, that:

- All health and care providers in an ICS to be connected to a shared care record by 2024 (the previous deadline for shared care records was March 2023)

- ICSs have already been asked to develop a plan that sets out digital investment priorities (ahead of fully costed plans required by June 2022).
- ICSs must work with partners to achieve 80% adoption of digital social care records among CQC-registered social care providers by March 2024.
- Each ICS will need to implement a population health platform with care coordination functionality to support joined up data for proactive population health management by 2025.

Basic shared care records are in place in all but one ICS, but they do not cover the full range of adult and children's services. In order that they do, the government will ensure that within six months of providers having an operational digital social care record in place, they are able to connect to their local shared care record. The government will also establish a suite of standards for social care, co-designed with the sector, and a standards development roadmap (by April 2022). Systems will also be put in place to link and combine real-time data to enable improved direct care and better analytics for population health management.

The government aims to address the specialist technology skills gap through professionalising the digital workforce, bringing in technology graduates, increasing the number of apprenticeships offered and harnessing entrepreneurial and analytical clinicians through new fellowships. The digital data and technology profession will be formally recognised within the NHS Agenda for Change employment framework.

Health and care workforce and carers

The white paper proposals aim to remove barriers to collaborative planning and working across the NHS and social care. This includes reviewing the regulatory and statutory requirements that prevent the flexible deployment of health and social care staff across sectors, and strengthening the role of integrated workforce planning at ICS and place level by:

- Identifying opportunities to strengthen guidance for systems and increase co-production with social care. Department of Health and Social Care (DHSC) will also incorporate this into guidance for integrated care partnerships (ICPs) to provide clarity of workforce planning responsibilities across the system.
- Working closely with NHS England and NHS Improvement (NHSE/I) and system leaders across the comprehensive health and care system to support the development of ICSs' "people operating model" and "one workforce" approach.

The paper refers to the workforce accountability report, as proposed in the health and care bill, as well as the long-term review that is being carried out by Health Education England (HEE) to identify strategic trends for the workforce. Regulated adult social care professions will be included in this framework for the first time, and it will also provide the information needed for ICBs to fulfil their role on shared workforce planning across health and social care services. Local leaders will be expected to consider how the health and care workforce in their place can be deployed in the most effective way.

The white paper recognises the current disparity between development opportunities for NHS and social care staff, and commits to identifying opportunities for joint continuous professional development across sectors, developing a more collective approach to promoting careers, and working with partners to improve initial training for integrated roles.

To help overcome barriers to staff moving between the NHS and social care, the government will consider developing a national delegation framework of appropriate clinical interventions, explore opportunities for cross-sector training and joint roles, increase the number of learning experiences in social care (starting with trainee nurses but with a long-term ambition for all health undergraduates to do so), and consider the introduction of an integrated skills passport (alongside additional measures set out in the adult social care reform white paper).

Conclusion, next steps and questions for implementation

The white paper sets out a series of questions on the approach to implementing shared outcomes, financial frameworks, accountability and oversight arrangements, workforce and data at place level. We will gather trust leaders' views on these topics over the coming months.

NHS Providers view

Trust leaders fully support the government's ambition to deliver better integrated health and care services for patients, including at the level of place. A number of trusts are already successfully leading the integration of services, more integrated staffing models and pooled budgets with their local authority partners across a range of services.

However, these proposals are complex and may have far-reaching implications that need to be worked through with the sector before being taken forward. Introducing a single person accountable for health and care at place, and expecting greater pooling of NHS and social care funding – without altering the underlying financial flows, infrastructure and accountabilities – will introduce further risk into an already fragile, and under-funded, system. This is particularly concerning given the absence of

wider reform, and financial support, for social care. There needs to be much greater weight given to the evidence that behavioural, relational and cultural factors play a more decisive role in the delivery of integrated care than structural reform or funding mechanisms. Under current proposals, trust leaders and their social care partners will still need to overcome the challenges to joint working that two very different systems and cultures bring.

We summarise trust leaders' key concerns in the section below, which is based on our engagement to date, our work on wider elements of the integration agenda such as the health and care bill, and the myriad pieces of ICS-related guidance produced last year. We fed back trust leaders' views on the emerging integration white paper proposals in November 2021, both in writing to ministers and in meetings with Number 10, DHSC, HM Treasury and NHSE/I. We will continue to contribute to the government's formal stakeholder input process and facilitate engagement with members in response to the implementation questions set out in the paper.

Context and timeframes

Health and care leaders are currently managing unprecedented operational pressures at the same time as significant reform, with the health and care bill currently expected to become law in April 2022. In our engagement with the government ahead of this publication, we asked that these challenges were not exacerbated by the introduction of new, overlapping structures or conflicting, additional policy aims. We are therefore concerned that, by setting national expectations at place level, the white paper risks cutting across the bill and role of ICSs. In addition, the timescales for implementation will be extremely challenging given ongoing pandemic disruption, the recovery task, and in the context of the delay to full implementation of statutory ICSs to July. To avoid further disruption, we welcome the white paper's assurances that there are no national plans to make further changes to ICB boundaries.

Governance and accountability

We are pleased to see the paper maintains flexibility for places to decide which governance models and leadership arrangements to adopt, as long as they meet certain criteria such as providing a clear decision-making structure. This is essential as the role of places varies significantly and necessarily between ICSs based on their population size and geographic characteristics, which the paper acknowledges.

However, we are very concerned that governance and accountability structures at all levels of system working, including at place, are already being made less clear, under the health and care bill. It is very striking how many trust leaders are currently saying that accountability between trust boards, ICBs,

ICPs and NHSE/I regions feels very opaque and potentially confused. Adding an additional formal layer of place-based accountability for outcomes, without being clear how these accountabilities fit with those of ICBs, trusts or local authorities, would blur lines of accountability even further. In particular, it is hard to see how a single leader can be accountable for the delivery of shared outcomes across the NHS and local authorities given existing statutory accountabilities for both systems will remain in place. This will lead to much greater complexity and high levels of risk being carried across all the different players in a system.

Increased pooling of NHS and adult social care budgets

Pooling budgets can be a good way of aligning decision-making across the NHS and social care, and many ICSs are already considering what budgets it would make sense to delegate to places based on their local contexts. We are pleased that the government "will not at this point mandate how [pooling budgets] is achieved", which would have undermined the intention to create a flexible national policy and legislative framework for ICSs.

While we welcome the flexibility for local areas to decide the degree to which they pool budgets, there is still an expectation that a "significant and, in many cases, growing proportion" of health and care spend will eventually be pooled at place level. We remain concerned that this approach would risk the NHS budget becoming exposed to severe and well-established funding pressures in social care. Trust leaders' experience of pooling budgets to date shows that both the NHS and social care need to be able to commit to making fair contributions and welcome the commitment that pooling budgets will continue to be subject to both NHS and local authority partners agreeing what constitutes a fair and appropriate contribution. We will be seeking sufficient safeguards for local partners in any forthcoming guidance in this regard. We are also concerned that this proposal overlooks the reality that delegation to places does not make sense in every ICS, as the composition and footprints of local communities, local authorities and NHS organisations differ considerably.

While trust leaders will welcome the commitment to review section 75 arrangements, we are concerned that a focus on the mechanics of how to grow pooled budgets quickly risks detracting from more strategic objectives that would actually drive greater integration on the ground.

Shared outcomes and oversight

The paper's emphasis on shared outcomes at place level is welcome, including the flexibility for places to identify their local priorities and commitment to co-designing any nationally defined outcomes with trusts, ICSs and wider system partners. However, while the individual case studies are helpful, there is a missed opportunity to describe the value and benefits of integration for people and communities

clearly and meaningfully. While the paper mentions the outcomes framework will focus on tackling health inequalities, we will want to see this embedded further in national guidance and local ways of working.

The paper positions the CQC as having a growing and significant role in considering outcomes agreed at place level, in addition to its new role in assessing ICSs and local authorities' delivery of their social care duties, and its existing role regulating providers of primary, secondary and social care. We are concerned that new duties relating to place could be duplicative, and could place a significant additional burden on CQC's capacity. In addition, these new roles, which will involve a very different type of oversight to that currently undertaken by CQC, are untested. It will therefore be essential for the CQC to build confidence among those it regulates in its ability to make judgements on integrated planning and delivery, and this will be particularly challenging given the limited engagement time available. It also raises the question of the oversight roles for DHSC, NHSE/I and the Department for Levelling Up, Housing and Communities given that statutory accountabilities for trusts and local authorities are not changing. We urge the national regulators to consult in detail with the provider sector to ensure the regulatory system is fit for purpose.

Children and young people's services

Local government, the NHS and wider partners all work across 'cradle to grave' services which span a person's lifetime, and they will find it difficult to disaggregate arrangements for children's and adult services. It is therefore disappointing to see that children's social care is not within scope of this paper, although places are encouraged to consider integration between adult and children's services wherever possible. We agree that ICSs must prioritise the needs of children and young people, but are concerned that treating these services separately in national policy documents will risk reinforcing the fragmentation the white paper aims to overcome (e.g. mental health services for children and adults, paediatric services in acute trusts, community health services district nursing functions).

Workforce

While the aspirations for a more integrated health and care workforce is welcome, the paper fails to acknowledge the scale of staff shortages in the NHS and social care sector and the national action required to tackle them. One of the challenges will be the disparity in pay levels and conditions of employment between staff from the two sectors.

It remains unclear how ICBs and/or place-based partnerships will adopt workforce planning responsibilities when the levers, and information to do so, sits outside of their control (e.g. medical and nursing training places) and in the absence of the data, tools and support to do this. We

understand HEE's long-term strategic framework will not include the numbers of staff required, but systems need to be supported with much better national planning and information on workforce needs. There is a welcome emphasis on the potential of passporting, but no recognition of – or solutions to address – the practical, legal and contractual challenges that act as barriers to implementation.

Digital

The digital chapter helpfully draws on a range of existing and well-known initiatives. However, there are also some missed opportunities in the digital chapter, which also reads as a more prescriptive approach to rolling out EPR than previous iterations of the policy. We have also questioned the lens of the ICS without significant translation to place level, and the focus on digitising existing models of care rather than digital technologies which may reshape service delivery.

Press statement

Responding to the publication of the integration white paper, the deputy chief executive of NHS Providers, saffron Cordery, said:

"Trust leaders support the ambition to deliver better integrated health and care services for patients, and have been at the forefront of work to achieve this.

"That includes more integrated staffing models and pooled budgets with local authorities across a range of services.

"The government's proposals set out some helpful, long-term thinking on how to develop this approach.

"To us this document feels more like a 'green' than a 'white' paper which is in itself welcome. It addresses a lot of complex issues and sets out proposals with far reaching implications that will require extensive consultation and collaboration on solutions before being taken forward.

"We are pleased that it recognises the need for flexibility, allowing places to decide which governance arrangements and leadership models to adopt to meet certain criteria, rather than impose a single model.

"However, we still have significant concerns about the proposal for a single accountable person in each place. This could further complicate lines of responsibility in already complex, developing system working structures.

"Local partners across health and social care are making steps to better integrate health and care teams but they will need to be supported with much better national planning and information on workforce needs to make this a reality across the piste.

"And while pooled budgets can help align decision-making across the NHS and social care, here again, we support a flexible approach. Pooling NHS and social care budgets is no substitute for funding both systems appropriately and placing social care services on a sustainable footing.

"We would like to see greater weight given to behavioural, relational and cultural factors in supporting local integration, rather than the current focus on structures and funding mechanisms."

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