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NHS Providers response to the integration white paper questions for implementation

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS foundation trusts and trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has all trusts in England in voluntary membership, collectively accounting for £104bn of annual expenditure and employing 1.2 million staff.

Key messages

- Trust leaders fully support the government's ambition in the integration white paper to deliver better joined-up health and care services at place level. While this is the right long-term direction of travel for local communities, the integration white paper's proposals raise several issues that warrant further policy development and discussion before implementation. We would therefore encourage national colleagues to continue to engage in co-production with the sector as these proposals evolve.
- While the white paper seeks to support places to continue developing their existing leadership and governance arrangements, the introduction of a single accountable person at place risks undermining this intention, creating an additional formal layer in the system and further blurring accountability structures in integrated care systems (ICSs).
- We are concerned that this white paper could lead to a further legislative process over time, which would confuse and complicate accountabilities further.
- It is vital that national policymakers maintain the permissive approach to place-level arrangements taken by the health and care bill, and do not cut across existing place-based partnerships or statutory requirements for ICSs.
- Decisions about pooling and aligning NHS and social care budgets must also be taken locally. We welcome the government's decision not to mandate this "at this point", although we would welcome greater clarity on what a "growing proportion" of pooled funding means in practice. Trust leaders cite local government funding shortfalls as the key barrier to expanding pooled/aligned budgets, with the risk they combine to amplify existing pressures on NHS budgets.

- We welcome the focus on outcomes within the white paper, however the number of national priority outcomes should be kept to a minimum, to allow places to define their shared outcomes locally in response to population needs.
- Integrated workforce approaches across the NHS and social care provide opportunities to develop new roles and career pathways. For the full benefits of this to be realised, it will be important for leaders nationally and locally to take seriously the impact of different pay, terms and conditions between sectors.
- Sharing data across partners at place level will be a key enabler of integrated care. A local approach to improving capabilities is crucial as providers have different digital maturity levels.
- Research shows that behaviours, relationships, and leadership have a greater influence on integrated care than structural reform. We urge the government to prioritise these cultural factors when considering next steps for the white paper proposals alongside a focus on tackling workforce challenges.

Introduction

We welcome the opportunity to respond on behalf of trust leaders to the implementation questions in the integration white paper (February 2022). We fully support the government's ambition to accelerate the delivery of joined-up health and social care at place level for the benefit of local populations. Many trusts are already working with their partners to successfully lead greater integration through place-based partnerships. However, we also want to ensure that any unintended consequences are avoided, and that the potentially complex and far-reaching nature of these ambitious proposals is fully thought through.

The Department of Health and Social Care (DHSC) is seeking views on 18 implementation questions. We answer these directly where we can, reflecting the views of a broad spectrum of trust leaders. We have indicated where we feel there are issues that warrant further policy development and discussion before implementation questions can be addressed. We will soon publish a series of case studies highlighting the essential contribution of providers at place level, and the different priorities, leadership and governance arrangements they are developing. We hope this will prove helpful in illustrating the range of models under development, and the benefits of maintaining a flexible national policy framework.

We engaged with DHSC, NHS England and NHS Improvement (NHSE/I), Number 10 and HM Treasury on the draft white paper, including holding meetings with senior officials and setting out trust leaders' views in a paper in November 2021. We also wrote a briefing for members when the white paper was published in February 2022 and contributed to discussions in national stakeholder forums. We look forward to continuing to work with DHSC to develop these proposals further and ensure they are aligned with wider ICS reforms underway.

Finance

Overall position

Pooling budgets can be a helpful mechanism to enable aligned or joint decision-making across the NHS and social care, although our engagement with trust leaders has shown that this will not be appropriate for all places. We welcome the flexibility in the white paper for local areas to decide the degree to which they pool and/or align budgets, and the government's decision to not mandate pooled budgets "at this point". However, there is still an expectation in the white paper that a significant proportion of health and care spend will eventually be pooled at place level. We welcome further engagement with DHSC on what this proposal might mean in practice, not least as the main barrier to pooled/aligned budgets, from our members perspective, is the need for local government to be funded adequately.

As we noted in our written evidence to inform the white paper in November 2021, the integration of funding streams into a pooled budget does not guarantee the greater integration of services or improved patient care. The successful integration of services depends on relationships, behaviours, and joint working rather than who holds the funding. Indeed, the experience from more established ICSs shows that pooled budgets are a tool/mechanism that can support the delivery of specific local objectives but are not a means to facilitating integration in themselves and do not guarantee health outcomes will be improved.[1]

Trust leaders support the principle of subsidiarity and are exploring how ICBs may delegate budgets to places and/or provider collaboratives in 2023/24. However, it is essential that, in keeping with the principle of subsidiarity, these decisions are determined locally rather than mandated centrally. While this approach will add value in some systems, in other (often smaller) systems, some trusts are concerned that formal budget pooling, along with an "accountable person" at place, risks recreating sub-ICS planning footprints. This risks cutting across ICBs' responsibilities, making it more difficult to streamline bureaucracy, and undermining the benefits of reunifying NHS budgets at system level. There is also an ongoing need for realistic timeframes for implementation to ensure places are able to undertake accompanying cultural and behavioural development work.

[1] For example, see here.

The government must ensure that work around pooled/aligned budgets is informed by consultation with the Healthcare Financial Management Association (HFMA) and the Chartered Institute of Public Finance and Accountancy (CIPFA) – the representative bodies for the finance functions of the NHS and local government – who can advise effectively on harmonising reporting standards.

Implementation questions

1. *What guidance would be helpful in enabling local partners to develop simplified and proportionate pooled or aligned budgets?*

   The NHS and local government have different financial reporting standards. Trust leaders believe that streamlined and targeted guidance may help system partners overcome the frictions between accounting systems. If these reporting arrangements are to be simplified, trust leaders would welcome some insight into how this would be tested and against which areas of NHS spend.

   This guidance would need to be directed to local authorities as well as the NHS for it to be effective. Trusts agree that further engagement from the Local Government Association (LGA), HFMA and CIPFA on this issue can help to make any guidance relevant for NHS and local authority officers.

   Trusts would also welcome further information on how a shared outcomes framework (and the data required to enable its development) will support local systems to develop pooled budgeting arrangements.

2. *What examples are there of effective pooling or alignment of resources to integrate care/work to improve outcomes? What were critical success factors?*

   Many place-based partnerships are exploring where further joint commissioning via section 75 agreements would deliver improvements for service users and the system. In some areas such arrangements have been in place for several years. Examples of effective joint commissioning can be seen in Croydon, Calderdale, Northumberland and the ten localities in the Greater Manchester ICS.

   For example, in Salford the council and the CCG have pooled resources and now have a combined budget for adult health and social care services. The money can therefore be

used more flexibly across both sectors to meet the needs of the changing population and provide better joined up care for patients.

Although there are some examples of effective pooling/alignment of resources, pooled budgets will not be the most appropriate means of integration for all places. It is also important to recognise that the evidence base for the relative strengths and weaknesses of different models is only just beginning to emerge. The expectation that a "growing proportion" of health and care spend will be pooled at place level could also risk undermining otherwise constructive and forward-looking conversations around the wider determinants of health by forcing conversations to become transactional and shorter-term in focus. The government must therefore continue to allow for local flexibility when establishing place-based arrangements and allow partners to make decisions that best suit their local communities.

3. *What features of the current pooling regime (section 75) could be improved and how? Are there any barriers, regulatory or bureaucratic, that would need to be addressed?*

An adequately funded social care system is needed before pooled budgets can be a reality. Some trusts have noted instances of significant budget reductions in local authority funding leading to funding being diverted away from NHS services where a section 75 agreement has been implemented.

Some trusts have also been unable to put section 75 agreements in place because of the difficulties in enabling meaningful risk share arrangements: without this risk share discussion between both parties, a budget pooling structure will not work. The review of existing arrangements must therefore explore how to align the accountability structures underpinning pooled funding streams, where both parties are accountable for the allocation of funding for specific services. In addition, different standards of regulation across local authorities and NHS can hinder the efficacy of unified health and social care arrangements.

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 diverting focus away from interventions that would actually drive greater integration on the ground.

Accountability

Overall position

Regarding the requirement for places to have a single accountable person for delivering shared outcomes by spring 2023, we support the flexible approach in the white paper for partners at place to choose who fulfils this role and what outcomes they will be responsible for delivering.

However, trust leaders already report concerns about the complexity and lack of clarity around accountabilities between trust boards, ICBs, integrated care partnerships (ICPs) and NHSE/I regions. Adding a formal layer of place-based accountability, while maintaining NHS and local government accountabilities, risks adding complexity and increasing ambiguity. We are concerned about the suggestion in some quarters that a further legislative process is being considered to embed single accountable officers at place level.

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, rightly, remain in place. The white paper makes clear that the single accountable person could be an individual with a dual role across health and care or an individual lead for a place board. However, this does not explain how they will be held to account for both health and care budgets and the different services they fund, or who they would be accountable to. Greater integration at local levels would need to be replicated in policy making, funding, and overall accountability arrangements between DHSC and the Department for Levelling Up, Housing and Communities (DLUHC).

We are also concerned that the proposal for a single accountable person lacks flexibility. Places should have the freedom to decide their leadership and governance arrangements, which the white paper does acknowledge, as the role of places varies significantly and necessarily between ICSs based on their population size and geographic characteristics. For instance, some trust leaders operating in smaller systems where the ICS and place footprints are one and the same, believe that the expectation to introduce a single accountable person will not add value. Allowing for local flexibility will avoid partners being distracted by the requirement to implement a policy that will not necessarily benefit their local communities. We would like to explore these issues with DHSC before addressing questions about implementation.

The white paper did not acknowledge the important role of provider collaboratives within/across ICSs, and we look forward to discussing how the accountability arrangements for all these various forms of collaboration will work in practice. In reality, trusts will be simultaneously involved in multiple provider collaborations at scale, as well as developing deeper 'vertical integration' around a place-based footprint with local partners.

Past experience makes clear that behaviours, relationships, culture and leadership have a greater impact on the delivery of integrated care than structural reform. System partners at place must be given the local flexibility to build relationships and develop a shared vision; they must also be given the time to develop these relationships in an enabling environment.

Outcomes

Overall position

We welcome the white paper's commitment to improving health and care outcomes through better integrated care. Trust leaders are cautiously optimistic about proposals for a national outcomes framework which allows places to define a set of shared outcomes locally. We encourage the government to keep the number of national priorities to a minimum, to allow for local flexibility. We also welcome the government's commitment to co-design any nationally defined outcomes with trusts, ICSs and wider system partners.

The need to address health inequalities should be considered as a convening principle for places, with shared outcomes providing a common goal for trusts and system partners in tackling the wider determinants of health. Tackling health inequalities is often a shared priority for partners at place level. Local partners often have links with local communities, intelligence and evidence to ensure this work is effective. However there can also be a lack of common language or shared understanding of priorities, which can be a barrier to progress. Systems and their constituent organisations should therefore be enabled to develop these priorities to ensure there is mutual understanding locally.

Questions remain around how the ambitious proposals in the white paper will be implemented and overseen. It is not yet clear what role NHSE/I will take in overseeing place-based arrangements and how this may fit with their emerging, new operating model. The white paper positions the Care Quality Commission (CQC) as having a growing and significant role in considering outcomes agreed at place level, alongside its role in assessing ICSs and local authorities' delivery of their social care duties. While we support the CQC having an appropriate role in system oversight, we are concerned that new duties relating to place could be duplicative and could place a significant additional burden on CQC's capacity. Expanding the remit of the CQC in this way, which will involve developing a new

type of oversight, is untested and will come at a time when the regulator's role is evolving significantly under the health and care act to assess the performance of systems. 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.

Before we have clarity on these questions and the regulatory structure, we are unable to comment fully on the role and benefits of local and national outcomes. We therefore urge the national regulators to consult in detail with the provider sector to ensure the regulatory system and any shared outcomes frameworks are fit for purpose.

Workforce

Overall position

To ensure the NHS and social care workforce is sustainable, a fully costed and funded multi-year national workforce plan is needed for both sectors. As colleagues within DHSC will be aware, NHS Providers is a member of a coalition of over 100 organisations seeking to introduce a new duty on workforce planning within the health and care bill including the publication of regular, independent, multi-year projections of workforce need at a national level.

A national workforce plan should look to improve learning and development opportunities for staff, progression within and between sectors, and place-based workforce integration, as outlined in the white paper. It must also incorporate local level input, captured in the 'one workforce' approach that will be adopted by ICBs, which aims to join up recruitment and workforce planning to ease workforce shortages and share staff across organisations.

However in order to realise the aspirations of a more integrated health and care workforce, the government must acknowledge the scale of staff shortages in the NHS and social care sectors and take national action to tackle them. One of the key issues to consider in a unified workforce plan between health and social care is the disparity in pay levels and conditions of employment between staff from the two sectors. This is complicated further by primary care colleagues also being on different pay, terms and conditions.

Staffing issues must also be addressed in Health Education England (HEE)'s work to review the NHS's 15-year strategic framework for workforce, which will expand to cover social care for the first time. The long-term ambition must be to focus on how sufficient numbers of health and social care staff will be trained, recruited, and retained in the future. It is necessary to understand what training should look

like now in order for staff to deliver changing models of care and ensuring the necessary funding will available.

Implementation questions

4. *What are the key opportunities and challenges for ensuring that we maximise the role of the health and care workforce in providing integrated care?*

The opportunities presented by a closer and more integrated health and care workforce are clear, for example:

- We have heard from trusts that successful workforce integration can enable efficiencies and better outcomes for people who receive more joined up and personalised care.
- More integrated working and workforce planning can help reduce competition between health and social care organisations who are recruiting staff from the same talent pool
- Multi-agency teams and integrated workforces already allow staff to deliver services across organisational boundaries.
- Integrated working provides the opportunity to develop new roles and career opportunities across the sector, aiding retention with options for more movement between roles and organisations.
- Adopting an integrated approach also gives the opportunity for teams to better understand each other's roles and build more comprehensive support networks around an individual's care needs. This could be through multidisciplinary teams which share skills, cultures and ways of working to provide a more coordinated and collaborative approach to patient care.

Although the opportunities of an integrated workforce are evident and being realised in some places, there are a number of barriers preventing widespread integrated working from becoming a reality. For example, staff shortages are a consistent challenge: in order to realise the ambitions of joined up working, there needs to be sufficient staff, both clinical and non-clinical, to dedicate time and resource to coordinate teams across different organisations, align working cultures, and offer joint training and development opportunities.

Another challenge to integrated care is the lack of parity in pay, terms and conditions for different roles across the system. For example, a multi-disciplinary team with staff from primary care, community services and social care would have significant differences in pay between

team members from the NHS and adult social care workforce. These instances negatively impact staff morale and retention.

The variability of, and lack of time to undertake, training opportunities is also a barrier to workforce integration. This can lead to duplication of effort (for instance, staff repeating mandatory training in different settings), and hinders a 'one workforce' approach through the disparity of opportunities between organisations and sectors. Further funding for learning and development is therefore needed, on top of the £500m recently allocated for social care staff, to encourage people to enter and stay in the sector.

It is also important to ensure training opportunities, medical and nursing placements take place in a range of settings, including within the community, in primary care and in social care, offering new entrants the opportunity to understand a broader range of care settings. Professional regulation, guidance and advice, must also keep pace with the developing need for more blended roles which may cover different aspects of health and/or social care.

5. *How can we ensure the health and social care workforces are able to work together in different settings and as effectively as possible?*

The health and social care workforce will not be able to work together effectively until there are sustainable numbers within the system as a whole. However, the white paper does not acknowledge the scale of staff shortages in either sector or the national action required to tackle them. It is therefore vital that the government recognises the challenge and looks to address the vacancy, recruitment, and retention issues across the sectors. As part of this, the level of training and career opportunities must be assessed and updated in line with how care is expected to be delivered both now and in the future.

As more staff take non-linear routes through their training and careers, with increased movement between roles, HEE is developing 'generalist training', based on their 2020 Future Doctor report. We are interested in how this approach to training could be applied for other staff groups across the health and social care sector to encourage integrated working. This could provide staff with a base level of knowledge and allow them to access roles across both sectors, particularly for social care staff, who are often constrained by inadequate access to training and development opportunities. The creation of new, cross-sector roles could encourage integrated working as well as expand recruitment by offering more career options for staff taking non-traditional career routes.

Harmonising contracts and employment models, particularly for social care staff who often operate under less favourable terms and conditions, would also enable health and care staff to work together more effectively by reducing competition within systems and encouraging recruitment and retention with a fair wage and conditions for all staff. This could be done through the creation of a pay framework for social care staff that is either fully integrated with Agenda for Change in the NHS or which offers comparable rates – these measures have also been proposed by the Local Government Association and Association of Directors of Adult Social Services. We understand that any such proposals would come with financial cost, however they are worthy of exploration, and we would welcome opportunity to discuss the cost/benefit analysis with national policy makers.

Digital and data

Overall position

Improved digital and data capabilities are central to realising the opportunities of collaboration at place. Ensuring NHS and local authority datasets are connected, interoperable and underpinned by a strong digital infrastructure is key to enabling systems and places to develop data-led analysis and collective ICS ambitions, particularly in addressing health inequalities. We therefore welcome the fact that the integration white paper reflects this and outlines some ambitions for improving digital capabilities.

As part of this ambition to improve digital capabilities, it is important to acknowledge that systems and places around the country will be starting from different stages of digital maturity. It is therefore important that autonomy over place-based data and digital strategy decisions remain at a local level to better address the needs of local patient populations. We would caution against an overly prescriptive approach to digital capabilities.

Implementation questions

6. *What are the key challenges and opportunities in taking forward the policies set out in this paper, and what examples of advanced/good practice are there that could help?*

One of the key challenges to consider is the complexity of achieving interoperability between different health and social care software systems. Managing differing levels of digital maturity and infrastructure will be a logistical challenge and often the required capacity, resource and expertise to address this problem is limited and stretched.

It is also important to recognise the variation in digital advancement within systems. Some organisations (often acute trusts) will have invested a lot of time and money in implementing electronic patient record systems and may be bound by long term contracts with suppliers, whilst other trusts and providers will not. This could lead to complications when place-based partners look to integrate/join up information digitally via a single supplier. It could also be challenging in terms of how ICS allocations for digital funding are made.

Partners across systems have their own, potentially rich, sources of data on population health, activity rates, and prevalence, as well as data on communities vulnerable to situations that may affect their health including homelessness, poverty and unemployment. The data held by different parts of the system is not always available to the variety of partners who would benefit from its insight. The proposal set out in the white paper to put in place systems to link and combine data to enable better analytics for population health management from every health and adult social care provider is therefore a welcome step.