NHS Confederation

The integration white paper: our response

Briefing for the Department of Health and Social Care

April 2022

Background

The NHS Confederation had early opportunities to feed into the development of the integration white paper and we have welcomed that some of the more disruptive early proposals under consideration did not feature in the final version.

There will not, for instance, be mandatory pooled budgets between health and care, and the white paper adopts a consultative process to agreeing shared outcomes (both of which we strongly pressed for). We have been reassured, too, that the proposals will not necessitate further primary legislation beyond the existing health and care bill.

The white paper largely reinforces existing policy and we have broadly welcomed the direction it sets. Certain areas, such as around better data sharing and the focus on enabling workforce integration, could help to improve care for individuals. However, arguably the document should be considered a green rather than a white paper as there are several issues that will need further exploration and clarification.

Implementing the integration white paper

Ensuring that the proposals in the document are taken forward coherently – particularly those relating to governance and accountability – will not be straightforward.

The white paper concludes by setting out a series of questions across five different themes. The NHS Confederation's position on each theme, which address some or all of the questions posed, are given below. These include detail on how our members, leaders across the NHS, expect to be involved as the proposals set out in the white paper are taken forward over the coming months.

Outcomes

The NHS Confederation position

Outcomes frameworks

The integration white paper rightly focuses on the important principle of subsidiarity of decision-making, which begins in teams and neighbourhoods followed by places, systems and the centre. It also supports an important shift from incentivising activity to incentivising outcomes, which we believe will be fundamental to the NHS's ability to recovery from COVID-19 and to the success of integration of health and care.

We strongly support the local outcomes frameworks envisaged by the white paper, which will ensure place-level priorities are driven by the needs of local populations. Looking ahead, the emphasis must continue to be on local priorities and the government should allow as much flexibility as possible in the setting of them. Local leaders are closest to the needs of the populations they serve.

We understand the need for some national priorities. However, too much emphasis on centrally defined metrics risks excluding key partners such as local authorities, so they should be limited. It was concerning, therefore, that the recent NHS Mandate listed 13 priorities for NHS delivery in the year ahead. Our members have questioned whether each of these 13 will need to be reflected in outcomes frameworks at place, with concern about the idea of being held to account on too many priorities in the early years of place working.

Over time, as systems develop deeper insights into their populations and make measurable progress with health inequalities, it is hoped that there will be less need for national 'must-dos'.

Importantly, local priorities should not merely be 'NHS priorities' but those identified by the integrated care partnership (ICP), local authorities and voluntary, community and social enterprise (VCSE) sector partners, in partnership with regional offices of NHS England and NHS Improvement (NHSEI).

One of the questions resulting from the white paper is how the outcomes frameworks will link to the integrated care strategies to be developed by ICPs. It would be helpful to understand the relationship and interaction between the two in forthcoming ICP guidance.

Finally, setting local outcomes frameworks effectively will be complex and will take time as this should involve wide consultation with key stakeholders, such as those given above, and the public. We are concerned about the incredibly tight timelines given in the white paper for development of the frameworks and urge the Department of Health and Social Care (DHSC) to begin local engagement on framework development as soon as possible.

Oversight

The health and care system continues to develop more integrated ways of working, aiming to make sure that individuals receive care from different parts of the system in a more streamlined and person-centred way.

The outcomes frameworks across systems should not result in ICSs reinforcing old models of performance management, which have encouraged a focus on organisational incentives and which would undermine the shift from processes to outcomes.

Instead, such a shift to integration and collaboration provides an opportunity to regulate ICSs differently, supporting improvement across systems, focusing on whole patient pathways, and reinforcing partnership working.

ICS leadership at all levels should be able to develop fora for challenge and mutual accountability. Integrated care boards (ICBs) should be enabled to develop peer review and support mechanisms to drive improvement – sometimes in place of traditional regulatory processes.

Progress against local and national priorities will be measured by NHSEI and the CQC in their oversight of ICSs and the constituent organisations within them (although NHSEI oversight will be limited to the ICS and NHS organisations within the ICS). System regulation/oversight should add value on top of provider regulation by assessing the degree of integration of services based on patient experience and outcomes. This assessment should focus on the four purposes of ICSs, and evaluation of how well ICSs delegate functions to place and to provider collaboratives.

We believe system regulation should be driven by some key principles as outlined in our recent report and we urge the government to give regulators flexibility in developing their new frameworks. Intervention should take the form of support provided by peers within an ICS or outside, and inspections should be used only as a last resort.

Driving improvement

We believe the focus of both national and local outcomes should be on improving population health. However, to assess impact, national and local systems will need to develop rapid feedback loops to assess effectiveness of improvement.

Outcomes need to be designed with the principles of improvement and equity, as different systems will be on different improvement journeys and therefore an emphasis on locally determined outcomes is welcome.

Although incentivising integration is considered in the white paper, much more emphasis needs to be given to the aligning of financial incentives with closing equity gaps and shifting resource based on need / level of deprivation.

We support the requirements for regulators to embed place in their frameworks for systems and this should be as permissive as possible to allow for local variation. However, it would be useful to have some clearer design principles within the national policy framework of how ICSs work; what ‘place,’ ‘provider,’ ‘provider collaborative’ and ‘system’ mean, how they relate to one another and what each is responsible for. This should be agreed with regulators, so that systems know what basic model they are being regulated on.

Financial

The NHS Confederation position

Local leaders should have the flexibility to deploy resources to meet the health and care needs of their population, as necessary. NHS and local government organisations will be supported and encouraged to do more to align and pool budgets, both to ensure better use of resources to address immediate needs, but also to support long-term investment in population health and wellbeing.

There is no single definition of a pooled budget, either in accounting terms or in the legislation. We assume in this instance that a pooled fund is made up of partner organisations contributing agreed funds to a single pot, enabling an NHS body and a local authority to combine resources and jointly commission or manage an integrated service.

Aligned budgets are slightly less formal, enabling collaboration and joint decision-making but without any major changes to the governance around separate working; this could still be achieved through a single accountable person at place. Given the variable levels of partnership maturity, this may be a more palatable choice initially for some places and systems.

Clearly, the pooling or alignment of funds through a single accountable person does not override any individual organisation's statutory responsibilities or lines of internal accountability, so NHS and local authority partners will require clear reporting and accounting treatment, including agreement on what to do in the event of over or underspend.

It is essential that local authority partners feel ownership of ICSs; many ICSs are planning to have local authority partners as the chair or co-chair of their ICPs to foster such ownership. Systems need to ensure that there is value add for both local councillors and local authority officers in developing and driving the partnerships, rather than it being an NHS initiative which they attend. Establishing clear accountability for mutually agreed shared funds is an essential component of facilitating collaboration and integrated care services that will make ICSs a success.

Our members have reported that mutual trust, shared ownership and aligned objectives are the most common critical success factors to pooling or aligning resources. As always, improving these processes will be an iterative exercise as ICSs develop. The NHS Confederation therefore looks forward to working closely with DHSC and the Department for Levelling Up, Housing and Communities to collate examples of effective pooling or alignment of resources to integrate care and improve outcomes.

Finally, we are clear that the existing budget-pooling and alignment regime largely gives systems the legal mechanisms they need to jointly commission. We are clear that the biggest barrier to further pooling of budgets remains long-term underinvestment in local government and social care. However, other barriers often arise from regulation, specifically diverging priorities and outcomes frameworks, and from bureaucracy, specifically the tension

between centralised NHS decision-making and localised local authority decision-making as outlined above.

Accountability

The NHS Confederation response

One of the most notable aspects of the white paper is the expectation of a single person accountable for the delivery of a shared plan and outcomes at place level. Having a named accountable person at place may accelerate the devolution of decision-making, under the principle of subsidiarity, as there is a clear line of accountability back to the ICB. However, this accountable individual must ensure that other partners at place level feel involved and empowered to be part of the local decision-making about their local population. Some ICSs already have place leaders and are telling us that these are broadly working effectively.

The proposals in the white paper will not change the formal accountable officer duties within local authorities or those of the ICB chief executive. This has the potential to create a confusing landscape of individuals with overlapping responsibilities for the same populations, though most are navigating this complexity well.

DHSC and NHSEI should continue to support systems by offering administrative support where it is requested, but crucially the solutions on accountability and governance structures must be found and led locally. So far, over-prescription by the centre has been resisted in regards to place-based governance and this was welcomed by Professor Chris Ham in his recent report commissioned by the NHS Confederation:

> 'Although governance arrangements for ICBs have been prescribed in considerable detail by the centre, there remains latitude for the partners that make up systems to decide what other arrangements are needed. This is particularly the case in relation to place partnerships and provider collaboratives where most of the work of ICSs will be done. To avoid confusion, partners need to agree how decision-making forums within ICSs relate to each other and to established bodies like health and wellbeing boards.'

There is an important role here for NHSEI's regional teams, which should act as a supportive but critical friend to systems as they develop their governance arrangements. Though there is a risk that this tips over into over-burdensome sign off and approval, research undertaken for our recent State of ICSs report has shown that the vast majority of systems feel they have received good support from NHSEI and the regional teams so far. It will be important that regional teams continue to be clear to systems and their constituent places on the 'what,' but simply offer support on the 'how'.

A concern for some members is on how exactly place leaders will be enabled to achieve what is being asked of them. The white paper refers to 'a reliance on relationships and 'soft' levers, [which] can work well in areas where there are strong relationships built over time,

but [which] lacks resilience as it is vulnerable to change in leadership and is not universal' (p.26).

However, this reliance on relationships is only set to continue as it is not clear what (if any) new levers the white paper is introducing for the new accountable individuals at place. As indicated by the above, this will not be a problem in many areas where relationships are strong. Decision-making powers may be devolved to place leaders by local authorities and the ICB. But there will likely be challenges for accountable individuals in areas where relationships between health services, social care providers and local authorities are less mature. The question is how we can therefore support place leaders to deliver in such areas, which our place leaders forum will be well-placed to advise on over the coming months.

The NHS Confederation is currently working to support the development of effective place-based working across our membership. We will be happy to share our findings, including case studies, with DHSC should these be helpful.

Workforce

The NHS Confederation position

The key opportunity following the white paper is to ensure that the there is a system-wide approach to securing the right workforce (numbers, skills and values) to enable the health and care workforce to deliver the best care possible.

On behalf of members, the NHS Confederation (with others) has been calling for a fully funded workforce plan for social care and health for some time. While our dedicated staff continue to work flat out, we cannot keep demanding even more from the service without ensuring the NHS and social care has the tools it needs to do the job. Arguably, the most important tool for ICSs to succeed is a fully funded and fully staffed workforce.

Along with colleagues across professional bodies and health think tanks, we asked that the Secretary of State for Health and Social Care undertake a detailed assessment and analysis of future workforce demand and supply requirements for all health and care service across England. We outlined that this needed to:

1. be based on the projected health and care needs of the population across England for the following one-to-five years, five-to-ten years and ten-to-20 years
2. be undertaken every two years in response to changing population needs
3. be developed in collaboration with key stakeholders across the sector, including employers, providers, trade unions and professional organisations.
4. take full account of workforce intelligence, evidence and plans from providers and partners within integrated care systems.

Employers have engaged with the recent review and refresh of Framework 15, led by Health Education England (HEE), and the Secretary of State has also asked the NHS to develop and produce a workforce strategy for later this year. Both are welcome, however there is an

urgency for this work to move forward quickly and be available for colleagues to use. Having a workforce plan, with numbers, priorities and investment, would be hugely helpful to inform planning and decision-making at a local provider and system level as they prepare for delivering services differently to their local populations.

The key challenge within both workforces is that of recruitment and retention. There are high levels of workforce vacancies within the NHS. Vacancies at current levels are a barrier to delivery of integration. In social care the workforce shortages are combined with high levels of turnover and there is currently no comprehensive workforce plan. Continued investment to bridge the vacancy gap, grow the workforce and facilitate different way of working, is needed to address these challenges.

New ways of working are also important alongside investment in staffing numbers. While recognising that staff remain employed by different bodies across a system, there are opportunities to support unified approaches on areas such as workforce planning, access to training, and health and wellbeing support. Our members view these approaches as a clear priority and there are good examples of integrated work in, for example, Manchester, Dorset, London and Leeds.

There are a range of roles which have been pioneered where staff work across health and social care settings to provide services. An example of this is the peer support worker role that has been taken forward in mental health trusts, or the care co-ordinator and navigator roles in community settings.

The development of integrated planning, new roles and ways of working needs clearer support and encouragement by arm's-length bodies and regulators. The steps taken by HEE to provide greater transparency of education funding and investment to systems is a very welcome step, as is the commitment to devolve greater responsibility for planning to systems from the present overly centralised system. Leadership from the national heads of professions has been an important feature of implementing new ways of working over recent years (see for example, the nursing associate role) and it will be even more important as new roles are developed and concerns are raised about changes to areas of practice. The continued delays to the reform of professional regulators is slowing the contribution of 'new' professions such as medical associate professionals.

Digital and data

The NHS Confederation response

We are encouraged to see aspirations for ensuring digital maturity across all organisations and to raise digital standardisation across systems through the ICS First programme. The Digital Aspirant programme has brought benefits to NHS trusts to raise their digital maturity and while the What Good Looks Like framework sets out core principles for ICSs, it is important to acknowledge that organisations at system level are still all at different levels of digital maturity.

To meet minimum standards, a single clear framework for all organisations working together sharing digital technology and data should be set out, with a strong focus on interoperability. As we rightly work in partnership across health and social care, it must be understood that the level of requisite capacity in infrastructure, workforce, systems and training in digital maturity cannot be underestimated. We know already that NHS organisations are at different levels of digital capabilities and maturity, as well as digital infrastructure.

To effectively manage data and share information within, and between, systems is no small feat. This will require significant investment in terms of leadership, clarity of purpose, realistic goal-setting of what is achievable within the timelines and a clear framework for how joined-up integrated health digital systems will be delivered.

A clear set of agreed standards for interoperability is essential if systems – both viewed as digitally mature or not – are to work together across partners and at place level.

As organisations work more closely through provider collaboratives, ICSs and place-based partnerships, the ability to align technologically has become ever more important. Digital solutions will be a core pillar of the drive to deliver more integrated care, including the ability to share information across all partners in an individual's care pathway.

The NHS must seize one of the few positive legacies of the pandemic by embracing and furthering digital solutions and virtual delivery of care, where appropriate. However, there is still work to be done to robustly evaluate the impact of virtual care and these changes for both patients and staff.

Used well, virtual care has the potential to improve population health. It can allow for increased patient choice, better experience and broader access. But, to capitalise on the potential, the NHS will need to better understand the impact of virtual care across different communities and groups of patients. Crucially, evaluation and further adoption and spread of digital care throughout the NHS must be delivered without widening or creating new health inequalities.

Evaluations of impact and benefits can help to cement clinical support for continued use of technology. To be widely adopted by both patients and staff, technology needs to be easy to use and seamlessly incorporated into daily activities, and not feel like an additional burden.

Next steps

The NHS Confederation looks forward to continuing to feed into the development of the proposals set out in the white paper on behalf of our members across the NHS. We understand that over the coming months, progress will be made through fora such as the integration white paper delivery partners group and the more specific implementation groups. We intend to bring further intelligence to such groups from our ongoing engagement with NHS leaders.

While we are pleased to have had the opportunity to engage with DHSC on the integration white paper, we also urge the department to engage broadly on the development of its

proposals. Notably, the views of the VCSE sector and the public should help to shape the implementation of the white paper.

Should you have any questions or require any further information from the NHS Confederation at this stage then please contact William.Pett@nhsconfed.org