REPORT TO:	Health Policy & Performance Board (HPPB)
DATE:	29th June 2021
REPORTING OFFICER:	Strategic Director, People
PORTFOLIO:	Health & Wellbeing
SUBJECT:	White Paper – Integration and Innovation: Working together to improve health and social care for all
WARDS:	Borough Wide

1.0 PURPOSE OF THE REPORT

1.1 To provide a summary update on the key elements outlined in the Government White Paper "Integration and Innovation: working together to improve health and social care for all" February 2021.

2.0 RECOMMENDATION: That HPPB

a. Note the contents of the report and associated appendices.

3.0 SUPPORTING INFORMATION

Background

3.1 The Department of Health and Social Care (DHSC) has published a White Paper that sets out legislative proposals for a Health and Care Bill. Entitled 'Integration and innovation: working together to improve health and social care for all', the paper details proposals for NHS and social care reform, with a focus on integrated care and services adding value for end-users.

3.2 The legislative proposals are due to be implemented in 2022.

3.3 The White Paper recognises that the response to Covid-19 is the current priority; however, as the system emerges from the pandemic the legislative measures aim to assist with the recovery by bringing organisations together, removing the barriers and enabling change and innovations.

3.4 The legislative proposals are themed under the following headings:

A. Working together and supporting integration;
B. Reducing bureaucracy;
C. Improving accountability and enhancing public confidence; and
D. Additional proposals grouped as Social Care, Public Health and Safety and Quality.

A) Working Together and Supporting Integration

3.5 There are a number of proposals included in the white paper to enable different parts of the health and care system to work effectively. These include creating statutory

Integrated Care Systems (ICS) (see ***Appendix 1***), a duty to collaborate across the health and care system and a triple aim duty on health bodies.

3.6 Collaborative commissioning will enable "double delegation" back to Place supported by joint committees and joint appointments.

3.7 Other measures include: additional safeguard for financial sustainability; a power to impose capital spending limits on Foundation Trusts, in line with NHS England's recommendation is proposed. Patient Choice will be preserved and strengthened within systems. Legislation will also ensure more effective data sharing across the health and care system, which is critical to effective integration, and will enable the digital transformation of care pathways.

B) Reducing Bureaucracy

3.8 The White Paper includes a number of measures aimed at reducing bureaucracy, such as changes to competition rules for healthcare services; a simpler national tariff; new measures for creating new trusts and removing Local Education Training Boards (LETBs). The aim is to remove barriers that prevent organisations working together and enable them to provide joined up care in the interest of the patient/user.

3.9 Where procurement processes can add value they will continue, but changes to the competition rules for healthcare will eliminate the need for competitive tendering where it adds limited or no value. The proposed removal of Local Education Training Boards will give Health Education England more flexibility to adapt its regional operating model.

C) Improving Accountability and Enhancing Public Confidence

3.10 Several measures to improve accountability, empower organisations and provide public confidence are being proposed. This includes the formal merger for NHS England and NHS Improvement and enhanced powers of direction for the government. Measures include reforms to the mandate to NHS England to allow for more flexibility of timing; the power to transfer functions between Arm's Length Bodies, the removal of time limits on Special Health Authorities and new responsibilities for workforce planning.

3.11 An improved level of accountability will also be introduced within social care, with a new assurance framework allowing greater oversight of local authority delivery of care, and improved data collection.

3.12 There will be increased powers for the Secretary of State for Health and Social Care to enhance the accountability. This includes intervention powers and ability to set objectives for NHS England; ability to intervene in local service reconfiguration; obtain data from all registered adult social care providers about all services they provide, whether funded by the local authority or privately and the ability to make payments directly to adult social care providers. These powers do not allow the Secretary of State to direct local NHS organisations or intervene in individual clinical decisions.

D) Additional Proposals Grouped as Social Care, Public Health and Safety and Quality

3.13 The measures set out the Government's intention to modernise the legal framework that underpins the health and care system as well as putting in place targeted improvements for the delivery of public health and social care.

3.14 **Social Care**
Whilst the legislation is not the vehicle for wholescale social care or public health reform, the Government has sought to use it to address specific problems where legislative change could be beneficial. The Government has indicated that Social Care reforms remain a manifesto commitment and the Government intends to bring forward separate proposals on social care reforms later this year.

3.15 **ICS & Adult Social Care** - ICS legislation will complement and reinvigorate place-based structures for integration between the NHS and Social Care, such as Health and Wellbeing Boards, the Better Care Fund and pooled budget arrangements.. There will be published guidance that will offer support for how ICS Health and Care Partnerships can be used to align operating practices and culture with the legislative framework to ensure ICSs deliver for the Adult Social Care sector.

3.16 There does appear to be a stronger role for Local Authorities within the ICS with plans for a more clearly defined role for local authorities within the structure of an NHS ICS Body. It is hoped this will give Adult Social Care a greater voice in NHS planning and allocation.

3.17 **Quality and Availability of Data -** The proposal includes collection of additional data for social care services provided to those who self-fund care, linking client level data to health data on hours of care, services provided and their cost per person, together with data on financial flows, it will show how money flows to providers and workforce.

3.18 Improved data and data flows are needed. Changes to the data collected and frequency will need to be made, not just for central government assurance and oversight, but so that providers and consumers can access the data, they need while minimising the burden on data providers. The main focus within the paper is around a centralised data collection from social care providers. However, it is not clear how this links with the current plans to refresh the Adult Social Care Outcomes framework and develop an outcomes and performance framework.

3.19 Building on improvements made by existing tools, such as the capacity tracker, during the pandemic and an increased ability to gather data from social care providers (for Local Authority and private funded care) it will remedy gaps in available data to help understand capacity and risk in the system. The legislation is needed to ensure a continued high response rate that will provide high quality provider data collection. Long standing gaps in coverage in data on social care, both from Local Authorities and from care providers, have prevented making evidence based case for system change (with key gaps on self-funders, hours of care provided and cost per person) together with data on financial flows to providers and workforce mentioned. It is essential that Local Authorities ensure co-production/co-design; using the making it real principles (using the current capacity tracker will only focus on available capacity and risks to services; there is a danger of losing the focus on people and outcomes)

3.20 Integrated data flows are essential to ensure the system of care and support is fully understood. Historically this data and intelligence has sat with Local Authorities. Adult

Social Care understands the capacity and risks in our provider system. The implementation of the National Tracker did duplicate existing systems and approaches in Local Authorities. In addition, there are a number of data accuracy and interpretation issues with the National tracker. A local integrated data system would be the preferred approach; to really enable focus on place based care and support, delivering good outcomes to individuals.

3.21 With more and better data, it will enable improved future planning for the care of our population. There is a potential to generate significant health benefits such as increased independence, improved quality of care and higher patient satisfaction. However, ICS; system wide assurance verses sector assurances and selection of the right metrics needs to be considered. This could result in burden on Local Authorities and providers.

3.22 **New Assurance Framework -** The document proposes to introduce, through the Health and Care Bill, a new duty for the Care Quality Commission (CQC) to assess local authorities' delivery of their adult social care duties. It also adds that it wants to introduce a power for the Secretary of State to intervene where, following assessment under the new CQC duty, it is considered that a local authority is failing to meet their duties. CQC previously undertook Adult Social Care performance many years ago, which was very time consuming and overly bureaucratic. This system was replaced with Sector Led Improvement, which has demonstrated a number of successes over the years. There are concerns this could be a backward step.

3.23 The initial focus will be to improve the quality, timeliness and accessibility of adult social care data, with the assessment and intervention elements to be introduced over time as the final element of the assurance framework. There needs to be a balance between national system of assurance and sector led improvement. Consideration of existing tools; Peer reviews, Local Accounts, regional and national benchmarking.

3.24 There needs to be an opportunity for the Association of Directors of Adult Social Services to co-design methodology with CQC to ensure there are ratings that inspire and motivate improvement not create fear and apportion blame. Overall it appears that this a general move towards centralised control and assurance, similar to that seen in the NHS.

3.25 **Discharge to Assess: Model Changes** - The government is looking to bring forward measures to update approaches to this process to help facilitate smooth discharge, by putting in place a legal framework for a Discharge to Assess model, whereby NHS Continuing Healthcare (CHC) and NHS Funded Nursing Care (FNC) assessments, and Care Act assessments, can take place after an individual has been discharged from acute care. This will replace the existing legal requirement for all assessments to take place prior to discharge. At this stage, it is not clear what the funding arrangements for this will be.

3.26 **A Standalone Power for the Better Care Fund -** Legislation will be amending the process for setting the NHS mandate so that it is no longer set on a rolling annual basis. As such, there will be a standalone legislative power to support the Better Care Fund (BCF) and separate it from the mandate setting process. This will be a technical change, and will not have any impact on the function, purpose or policy intention for the fund.

3.27 **Public Health**

Alongside the Government's proposals for the future design of the public health system, including the creation of the National Institute for Health Protection (NIHP) and the closure of Public Health England, a range of targeted proposals in primary legislation relating to public health are proposed. They include:

- Making it easier for the Secretary of State to direct NHS England to discharge public health functions alongside the existing section 7A provisions.
- Help tackle obesity by introducing further restrictions on the advertising of high fat, salt and sugar foods, as well as a new power for ministers to alter certain food labelling requirements.
- The process for the fluoridation of water in England will be streamlined by moving the responsibilities for doing so, including consultation responsibilities, from local authorities to central government.

3.28 These public health measures will complement and augment the efforts of ICSs to make real inroads in improving population health in their areas, helping to tackle inequalities and 'level-up' across communities.

3.29 Building on the Government's obesity strategy, Tackling obesity: empowering adults and children to live healthier lives, the Government wants to help people make better-informed food choices and to help them improve their own health. The new powers will enable the swift introduction of key obesity strategy policies such as changes to our front-of-pack nutrition labelling scheme and mandatory alcohol calorie labelling, following consultation.

3.30 Water Fluoridation is clinically proven to improve oral health and reduce oral health inequalities. Since 2013, Local Authorities have had the power to propose, and consult on new fluoridation schemes, variations to existing schemes, and to terminate existing schemes and have however reported several difficulties with this process. In light of these challenges, the paper proposes giving the Secretary of State for Health and Social Care the power to directly introduce, vary or terminate water fluoridation schemes. This removes the burden from Local Authorities and will allow the Department to streamline processes and take responsibility for proposing any new fluoridation schemes. Central Government will also become responsible for the associated work, such as the cost of consultations, feasibility studies, and the capital and revenue costs associated with any new and existing schemes.

3.31 The Government suggests that the proposals will strengthen local public health systems, improve joint working on population health through ICSs, reinforce the role of local authorities as champions of health in local communities, strengthen the NHS's public health responsibilities, strengthen the role of the Department of Health and Social Care in health improvement, and drive more joint working across Government on prevention.

3.32 **Safety and Quality**

Measures included in the White Paper include:

- Healthcare Safety Investigation Branch (HSIB) will be put on a statutory footing; to improve the current regulatory landscape for healthcare professionals as needed;

- To establish a statutory medical examiner system within the NHS for the purpose of scrutinising all deaths which do not involve a coroner and increase transparency for the bereaved,
- Allow the Medicines and Healthcare products Regulatory Agency (MHRA) to develop and maintain publicly funded and operated medicine registries to provide patients and their prescribers, as well as regulators and the NHS, with the evidence they need to make evidence-based decisions.
- Measures to enable the Secretary of State to set requirements in relation to hospital food.
- Implement comprehensive reciprocal healthcare agreements with countries outside the EEA and Switzerland ('Rest of World countries') – expanding our ability to support the health of our citizens when they travel abroad, subject to bilateral agreements.

4.0 NHS SUMMARY

4.1 The White Paper proposed a significant number of changes relating to the NHS as described earlier, relating to working together and supporting integration, reducing bureaucracy, improving accountability and enhancing public confidence. The changes focus on the commissioning landscape and new governance arrangements with the creation of statutory ICSs.

4.2 Alongside the White Paper, on the same day, NHS England issued "Legislating for Integrated Care Systems: five recommendations to Government and Parliament" (see ***Appendix 2***).

4.3 The broad aim of the recommendations are a duty to collaborate across the health and care system and a triple aim duty on health bodies, which require health bodies, including ICSs, to ensure they pursue simultaneously the three aims of better health and wellbeing for everyone, better quality of health services for all individuals, and sustainable use of NHS resources.

4.4 Clinical Commissioning Group (CCG) functions and some NHS England functions will transfer to the new ICS NHS body; this means CCGs across England will cease to exist when the legislation comes into effect.

4.5 To ensure a smooth transition process an "employment commitment" for NHS staff (below board level) has been outlined and staff will be employed by the NHS ICS body.

4.6 ICSs will be different organisations to CCGs by bringing in perspectives and skills from a wider range of partners from Providers and Local Authorities.

4.7 There is still a requirement for strong place-based working within the NHS ICS body.

4.8 The NHS Provider landscape is not formally changing.

4.9 There is a commitment to working with patients in ensuring that patient care is not affected by any of the changes.

4.10 There is a continued commitment to national contractual arrangements across the primary care contractor professions and also to the primary and community services

funding guarantee. However, there has been no specific detail provided in relation to Primary Care Networks.

4.11 Mental Health investment identified in the NHS Long Term Plan is guaranteed.

4.12 There are a number of areas that remain ambiguous and currently further guidance is awaited from NHS England as to next steps and actions required.

5.0 IMPACT ON PLACE (ONE HALTON)

5.1 Place level commissioning will align geographically to a local authority boundary and the BCF will provide a tool for agreeing priorities.

5.2 There are no legislative provisions about arrangements at place level; the expectation is NHS England will work with ICS NHS bodies on different models for place-based arrangements.

5.3 Specifically the White Paper states, *"Place based arrangements between local authorities, the NHS and between providers of health and care services are at the core of integration and should be left to local organisations to arrange. We expect local areas to develop models to best meet their local circumstances. We would expect NHS England and other bodies to provide support and guidance, building on the insights already gained from the early wave ICSs. The statutory integrated care system (ICS) will also work to support places within its boundaries to integrate services and improve outcomes – recognising that different places will be at different stages of development and face different issues*."

5.4 It is expected that the ICS NHS Body will delegate significantly to Place. The exact division of roles and responsibilities between place and the ICS are still to be agreed.

5.5 There is a commitment for Health and Wellbeing Boards to remain in place and continue to have an important responsibility at place level to bring local partners together, as well as developing the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy.

5.6 Local authorities are recognised as an integral partner, including housing, leisure, employment services in addition to public health and social care.

5.7 One Halton already reports into the Health and Wellbeing Board. Further work will be needed to strengthen the governance process and refresh the Health and Wellbeing Strategy, due to be refreshed in 2022.

5.8 It is anticipated there will be a requirement for a Place Based Plan each year. Although the specific requirements remain unknown until further guidance is received from NHS England or the ICS. In the meantime, progress can be made to strengthen current governance arrangements for One Halton.

5.9 NEXT STEPS

5.10 One Halton will continue to work with Cheshire and Merseyside Health and Care Partnership as further guidance and information is shared in relation to the legislative proposals and NHS England recommendations. These will be reported and shared

formally with the Health and Wellbeing Board, as well as Health PPB, CCG Governing Body and other organisational boards as appropriate.

6.0 POLICY IMPLICATIONS

6.1 The Local Authority has a statutory responsibility to provide social care and to improve the health and well-being of the local population through the delivery of specialist public health advice and the continued access to health improvement services for residents in Halton. Changes to the legislation will require significant local and national policy change.

7.0 FINANCIAL IMPLICATIONS

7.1 The changes proposed in the White Paper will result in a systematic redesign of how local functions are designed, developed and deployed. Financial and resource implications are unknown at this moment but will form part of the consultation process and the local implementation of any changes required by the implementation of new legislation. Subject to its passage through Parliament, it is indicated that a new Bill will result in the introduction of these measures in 2022.

8.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

8.1 **Children and Young People in Halton**
The White Paper has limited detail relating to children, with the exception of childhood obesity, which is included within the Health and Wellbeing Strategy.

8.2 **Employment, Learning and Skills in Halton**
Employment, Learning and Skills are a key determinant of health and wellbeing and will therefore be a key consideration when developing strategies to address health inequalities.

8.3 **A Healthy Halton**
The proposals contained within the White Paper will shape and inform the council's delivery of the Health and Wellbeing strategy and will contribute to the achievement of the council's outcomes, including population health and reducing health inequalities as outlined in the priorities contained in the JSNA.

8.4 **A Safer Halton**
None

8.5 **Halton's Urban Renewal**
None

9.0 RISK ANALYSIS

9.1 As part of the development and implementation of the proposals outlined in the White Paper there is the potential for significant disruption to local system for the provision of health and wellbeing services for the local population. As any programme of implementation is developed a full risk analysis will need to be implemented and monitored.

10.0 EQUALITY AND DIVERSITY ISSUES

10.1 An Equality Impact Assessment (EIA) will be required as part of any significant change to the provision of local services or structures.

11.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

Document	Place of Inspection
Integration and Innovation: working together to improve health and social care for all – White Paper on Health and Social Care, HM Government. February 2021	https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version
Legislating for Integrated Care Systems: five recommendations to Government and Parliament, NHS England and NHS Improvement. February 2021	https://www.england.nhs.uk/publication/legislating-for-integrated-care-systems-five-recommendations-to-government-and-parliament/

Appendix 1: Integrated Care Systems

Every part of England will be covered by an Integrated Care System (ICS). ICSs will be accountable for outcomes of the health of the population, therefore they will work closely with local Health and Wellbeing Boards which have the experience as 'place-based' planners.

The ICS will be made up of a statutory ICS NHS Body and a separate statutory ICS Health and Care Partnership, bringing together the NHS, local government and partners.

The ICS NHS Body will be responsible for: developing a plan to meet the health needs of the population within their defined geography; developing a capital plan for the NHS providers within their health geography and securing the provision of health services to meet the needs of the system population.

The ICS NHS Body will merge some of the functions currently being fulfilled by STPs/ICSs with the functions of a CCG. It will have a unitary board and be directly accountable for NHS spend and performance within the system. The board will, as a minimum, include a chair, CEO, and representatives from NHS trusts, general practice, local authorities, and others determined locally, for example community health services (CHS) trusts and mental health trusts, and non-executives. Further guidance will be published by NHS England.

ICS Health and Care Partnership will be responsible for: developing a plan that addresses the wider health, public health, and social care needs of the system, as well as promoting partnership arrangements.

There is no intention to specify membership or detailed functions for the ICS Health and Care Partnership and local areas can appoint members and delegate functions as they think is appropriate.

The proposals around ICSs do not change the provider landscape, NHS Trusts and Foundation Trusts will remain separate statutory bodies with their functions and duties broadly as they are in the current legislation. The ICS NHS Body will not have the power to direct providers, and providers' relationships with the Care Quality Commission will remain unchanged. However, these arrangements will be supplemented by a new duty to compel providers to have regard to the system financial objectives.

Appendix 2

Alongside the white paper, NHS England also issued "Legislating for Integrated Care Systems: five recommendations to Government and Parliament"
The five recommendations are:

1. The Government should set out at the earliest opportunity how it intends to progress the NHS's own proposals for legislative change.

2. ICSs should be put on a clear statutory footing, but with minimum national legislative provision and prescription, and maximum local operational flexibility. Legislation should not dictate place-based arrangements.

3. The NHS ICS statutory body should be supported by a wider statutory health and care stakeholder partnership. Explicit provision should also be made for requirements about transparency.

4. There should be maximum local flexibility as to how the ICS health and care stakeholder partnership is constituted, for example using existing arrangements such as existing ICS partnership boards or health and wellbeing boards where these work well. The composition of the board of the NHS ICS statutory body itself must however be sufficiently streamlined to support effective decision-making. It must be able to take account of local circumstances as well as statutory national guidance. Legislation should be broadly permissive, mandating only that the members of the NHS ICS Board must include a chair and CEO and as a minimum also draw representation from (i) NHS trusts and Foundation Trusts, (ii) general practice, and (iii) a local authority. As with CCGs now, NHSE/I would approve ICS constitutions in line with national statutory guidance.

5. Provisions should enable the transfer of responsibility for primary medical, dental, ophthalmic and community pharmacy services by NHS England to the NHS ICS statutory body. Provision should also enable the transfer or delegation by NHS England of appropriate specialised and public health services we currently commission, and at the same time, NHS England should also retain the ability to specify national standards or requirements for NHS ICSs in relation to any of these existing direct commissioning functions.