Voluntary Sector North West

From this to that

NHS Whitepaper Summary – May 2021

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NHS whitepaper

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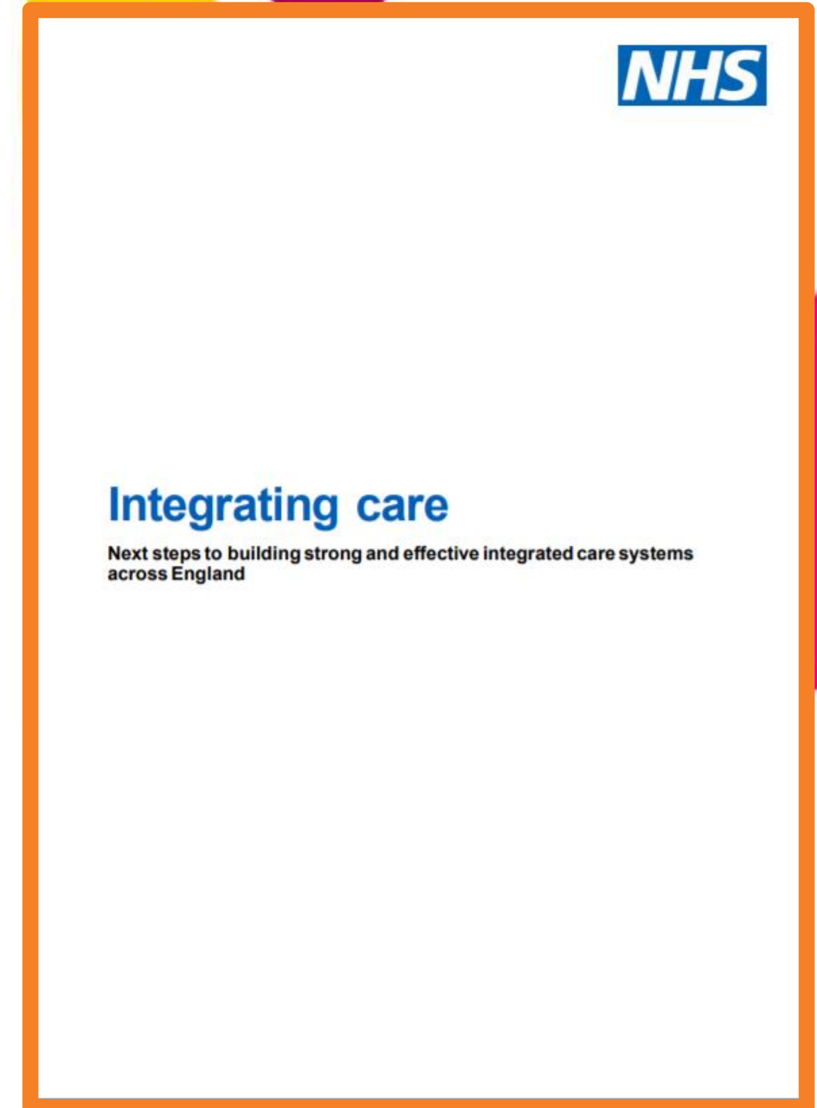
(white paper to be debated during the current parliamentary session)

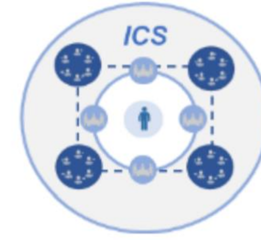
https://www.england.nhs.uk/wp-content/uploads/2021/01/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems.pdf



Establishing integrated care systems

1

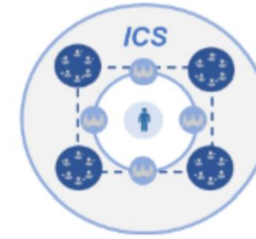
ICS systems in law (1)



Integrated care systems (ICSs) have become an increasingly familiar part of the health and care landscape in recent years. Many of the pioneer ICSs have been highly successful in bringing partners together to improve outcomes for the public, often supporting and supplementing arrangements at place level.

Existing ICS **arrangements are based on voluntary arrangements, rather than legislative provision**, and are therefore dependent on goodwill and mutual co-operation. There are also legislative constraints on the ability of organisations within an ICS to make decisions jointly.

ICS systems in law (2)



There is **no legal basis** at present for clinical commissioning groups (CCGs), NHS trusts and foundation trusts (FTs) to form a joint committee to which functions may be delegated, with the power to make decisions on behalf of the organisations within the ICS.

In order for ICSs to progress further, **legislative change is now required to give ICSs stronger and more streamlined decision-making authority,** and to embed accountability for system performance and delivery into the accountability arrangements of the NHS to government and Parliament.

The legislative provisions that are proposed for ICSs reflect NHS England's recommendations for change following their recent engagement on ICSs, and are **designed to provide a small set of consistent requirements for each system that the partners** who make up that system can then supplement with further arrangements and agreements that suit them.

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The Good, the Bad and the Ugly?

The Good: joined up working making it easier for patients

The Bad: relationships with CCG (often the gateway for VCFSE bodies) will end

The Ugly: the transition to a new system with new relationships to be created and developed

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Duty to collaborate

2

Duty to collaborate

Alongside the creation of statutory there will be a **new duty to promote collaboration across the healthcare, public health and social care system.** Many existing duties on health and care organisations are said to emphasize the role of the individual organisation and its own interests. The aim is to **rebalance these duties to reflect the need for all health and care organisations to work collaboratively.** When collaboration works well it leads to better outcomes for people, for example a successful early intervention can lead to people living independently and in their own homes for longer.

This proposal will place **a duty to collaborate on NHS organisations (both ICSs and providers) and local authorities.** This policy also provides the Secretary of State for Health and Social Care with the ability to issue guidance as to what delivery of this duty means in practice, in recognition of the fact that collaboration may look very different across different kinds of services.

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The Good, the Bad and the Ugly

The Good: should make it seamless for patients

The Bad: new systems to be designed

The Ugly: no mention of local control/devolved powers

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Triple aim

3

Triple aim

To further support integration, it proposed to implement NHS England’s recommendation for a shared duty that requires NHS organisations that plan services across a system (ICSs) and nationally (NHS England), and NHS providers of care (NHS Trusts and FTs) to have regard to the ‘triple aim’ of;

1. better health and wellbeing for everyone,
2. better quality of health services for all individuals
3. sustainable use of NHS resources

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The Good, the Bad and the Ugly

The Good: a laudable aim with excellent aspiration. This aim can be used when arguing for resources. There will be a need to measure outcomes.

The Bad: a new system and this section makes no reference beyond existing NHS operations. Social Care (local authority delivered) is not mentioned.

The Ugly: is a sustainable use of NHS resources a euphemism for cuts? Will this result in arguments between LA and NHS regarding budget apportionment (think LSP from mid noughties!)

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Power over foundation trusts capital spend limits

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Reserve power over foundation trusts capital spend limit (1)

It is planned to implement NHS England's recommendation for a **reserve power to set a capital spending limit on Foundation Trusts,** which will support the third aim of the triple aim duty, in relation to sustainable use of NHS resources. (Is this the answer to the "ugly" on the previous slide?)

Unlike NHS Trusts, which are set annual capital expenditure limits by NHS Improvement, NHS Foundation Trusts (FTs) currently have additional freedoms to borrow from commercial lenders and spend surpluses on capital projects (for example, new buildings, equipment or IT). However, capital expenditure by FTs still counts towards DHSC's overall Capital Delegated Expenditure Limit (CDEL).

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Reserve power over foundation trusts capital spend limit (2)

In recent years, given the restraint on capital expenditure and a growing maintenance backlog, the Department of Health and Social Care has had to restrict capital expenditure by Trusts and temporarily delay capital projects to ensure that it does not breach its CDEL limit.

A small number of FTs have previously indicated that they could push ahead with their individual schemes and use their own capital, without full consideration of the overall impact on the ICS and on CDEL as a whole. This could mean that at ICS or national level we may have to pause other schemes which may be strategically more beneficial or clinically required.

Dialogue is the first line of defence and remediation locally and nationally, but a targeted reserve power is required as a last resort to protect the system and ensure the most sustainable use of NHS resources.

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The Good, the Bad and the Ugly

The Good: there is recognition of maintenance backlogs etc. There is recognition of strategic investments

The Bad: wealthier areas may be able to use local funds to address this. A local gift of £10m for a scanner is surely a good thing? But what if there is no capacity to raise £10m in your area?

The Ugly: there remains an overall expenditure limit (not borrowing). Will this skew health outcomes towards wealthier areas?

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Joint committees

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Joint committees

Legislation does not currently allow NHS providers (NHS trusts and foundation trusts) and CCGs (which will become part of ICSs) to take joint decisions, either through a joint committee or committees-in-common, or for local authorities and other providers of NHS care to be involved in such partnership arrangements. Furthermore, Foundation Trust boards and individual directors **have a duty to act with a view to promoting the success of their organisation**. This creates an unhelpful barrier to joint working, and commissioners and providers currently have to use workarounds with complex governance arrangements in order to jointly discuss integrated care, incurring legal risk and administrative cost.

The ICS NHS body provisions go most of the way to **increasing the ease with which providers and commissioners could establish joint working** arrangements and support the effective implementation of integrated care. **NHS England's recommendation to allow ICSs and NHS providers to create joint committees could be a useful addition**, removing unnecessary barriers to joined-up decision making.

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The Good, the Bad and the Ugly

The Good: streamlined system proposed.

The Bad: no mention of the same “duty of care to organisation” applying outside of the NHS.

The Ugly: decision making seemingly not envisaged as co-produced.

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Collaborative commissioning

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Collaborative commissioning

Support the health and care system to work collaboratively and flexibly across different footprints. Many local areas, across England, have been **exploring ways of working more collaboratively and are seeking to align decisions and pool budgets** between CCGs and NHS England, across CCGs, and between CCGs and local authorities (LAs).

Existing NHS legislative mechanisms make it difficult to do this, forcing local systems to adopt complex workarounds to be able to make lawful decisions across a wider population footprint. In practice, these arrangements can be cumbersome, difficult to manage and can slow decision-making processes. It is intended to implement NHS England's recommendation **to change the underpinning NHS legislation to remove these barriers and streamline and strengthen the governance for this type of decision-making.**

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The Good, the Bad and the Ugly

The Good: joining up action is seen as essential (and supports the change in department title)

The Bad: experience of aligning/pooling/joint budgeting has been mixed to say the least. Money = power. Economies of scale may prevail.

The Ugly: new systems to be devised with new legislation.

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Joint appointments

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Joint appointments

Joint appointments of executive directors can help to foster **joint decision making, enhance local leadership and improve the delivery of integrated care.** These can also help to **reduce management costs and engender a culture of collective responsibility** across organisations.

In line with NHS England's recommendation, it proposed to introduce **a specific power to issue guidance on joint appointments between NHS Bodies**; NHS Bodies and local authorities; and NHS Bodies and Combined Authorities. This will **aid the development** and delivery of integrated care and will ensure that there is a clear set of criteria for organisations to consider when making joint appointments.

NHS England will need to keep the guidance under review, and if substantial changes to it are considered, they will need to consult appropriate organisations before the revision is published.

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The Good, the Bad and the Ugly

The Good: there is an aspiration of joint responsibility across organisations.

The Bad: it is not indicated how this will work.

The Ugly: VCFSE bodies appear to be outside of the responsibility loop. Will this mean “internal commissioning”?

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Data sharing

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Data sharing

Building on the successful data sharing in response to COVID-19, ensure that health and care **organisations use data, when they can do so and with appropriate safeguards**, for the benefit of individuals and the wider health and social care system. The forthcoming **Data Strategy for Health and Care will set out a range of proposals** to address structural, cultural/behavioural and legislative barriers to data sharing and a more flexible legislative framework to improve data access and interoperability, including enabling the safe sharing of data in support of individual care, population health and the effective functioning of the system. As part of this work, there is an exploration of where achieving these objectives may require primary legislation.

The measures in this bill will help NHS organisations join up, to provide better care for the public and to plan services. None of the measures here will erode the protection of personal information.

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The Good, the Bad and the Ugly

The Good: the need for data sharing is recognised and the opening preamble (quoted on previous slide) uses “organisations”.

The Bad: new data protection systems may come into play. Possible two tier systems within one organisation.

The Ugly: the italicised section (quoted on previous supplies) reverts to NHS speak.

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Patient choice

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Patient choice (1)

Integrated services **provide an opportunity to offer joined up care to all and provide clear information on the choices people have** in how and where their care is delivered. A **patient's right to choose** where and who will provide their health and care needs will be preserved and strengthened in the new system arrangements.

The NHS's Long Term Plan (LTP) makes specific proposals to **strengthen patient choice and control.** The LTP states that the ability of patients to choose where they have their treatment remains **a powerful tool for delivering improved waiting times and patient experiences of care**. The LTP also states that the NHS will continue to provide patients with a wide choice of options for quick elective care, including making use of available Independent Sector capacity. The protections and rights in relation to patient choice and the Any Qualified Provider (AQP) requirements are fundamentally set out in the current legislation.

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Patient choice (2)

As part of the wider package of changes to the arrangement of healthcare services, it is proposed to repeal section 75 of the Health and Social Care Act 2012 Act including the Procurement, Patient Choice and Competition Regulations 2013 and replace the powers in primary legislation under which they are made with a new provider selection regime. Under the new model, **bodies that arrange NHS Services as the decision-making bodies will be required to protect, promote and facilitate patient choice with respect to services or treatment.** We also want to make clearer the rules, circumstances and processes around the operation of Any Qualified Provider (AQP).

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The Good, the Bad and the Ugly

The Good: this is what it should be about and where VCFSE bodies can make a difference.

The Bad: it appears at the bottom of the list which may reflect the priority.

The Ugly: new rules/legislation and no mention of money!

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Care Conundrum

"SIR – I began my career in social work in 1965. The hot topic at that time was how social care and healthcare could better work together. That conundrum remains, not because of resource constraints but simply because of the intractable question at its heart: who controls the resulting service?

Is it to be local government, through locally elected members, or central government through Parliament? Therein lies the rub: the control of social care is locally determined but within parameters set by central government. The control of healthcare is firmly embedded in Whitehall. Neither entity is likely to give ground.

The problem, therefore, is not about resources but power."

Robin SeQueira
Former Director of Social Services
Dorset County Council
Lytchett Minster, Dorset" *

***Letter from the Daily Telegraph, 13th May 2021**

Find the NHS paper here:
https://www.england.nhs.uk/publication/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems-across-england/

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