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NHS WHITE PAPER: “INTEGRATION AND INNOVATION: WORKING TOGETHER TO IMPROVE HEALTH AND SOCIAL CARE FOR ALL”

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Purpose of the paper	To present the White Paper on “ <i>Integration and innovation working together to improve health and social care for all</i> ”.		
Key control			
Action required	To note		
Previously discussed at/ informed by			
Previously approved at:	Academy/Group	Date	

Key Options, Issues and Risks

The Department for Health and Social Care published the White Paper [Integration and Innovation: working together to improve health and social care for all](#) on 11 February 2021. The Paper sets out the government’s ambitions for the forthcoming Health Bill.

The main provisions in the White Paper intend to make it easier for NHS bodies, local authorities and others to work together more effectively, to reduce bureaucracy and enhance public confidence and accountability. The key points are:

- Integrated Care Systems will be put on a statutory footing, with two key parts – an NHS Body, which will take on functions from CCGs and NHS England, and a health and care partnership similar to the one we currently have. Place based working will continue, with a push to ensure all ‘places’ become Integrated Care Partnerships.
- All parts of the health and care system will have a statutory duty to collaborate.
- There will be changes around competition, commissioning and procurement.
- NHS England and NHS Improvement will formally merge, with the NHS Trust Development Authority and Monitor being abolished.

This paper sets out the content of the White Paper and the implications for BTHFT.

The Board is asked to **note** the content of the paper.

Analysis

NHS England published an engagement document in November 2020 which outlined proposals to put Integrated Care Systems onto a statutory footing. BTHFT responded to this document in its own right as well as contributing to Place, WYAAT and ICS submissions. The responses to this engagement have informed the development of the White Paper.

The White Paper sets out the intention to support recovery from the Covid-19 pandemic and to ensure that the good relationships and working arrangements which have developed and solidified through the pandemic are not lost. There is also a need to address health inequalities, which have been highlighted by the way in which Covid has affected some parts of the population more than others, and to support people to live longer, healthier lives. Whilst the White Paper goes some way to address these, additional proposals will be made later in the year on social care and public health reform, and taken with the

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recently published white paper on mental health will form a suite of sweeping reform across the health and care system.

Underpinning this ambition and the provisions in the paper is the new Triple Aim of a shared duty to achieve i) better health and wellbeing for everyone, ii) better care for all people, and iii) sustainable use of NHS resources.

1. Proposals for legislation

Integrated Care Systems

Integrated care systems (ICSs) will be put on a statutory footing. Each ICS will have two parts:

- A formal NHS body which will take on responsibilities from CCGs and will take on some of the commissioning functions currently carried out by NHS England. This body will be responsible for the day to day running of the ICS, planning and allocation decisions. The minimum membership of the Board will be a chair, chief executive, and representatives from NHS trusts, general practice and local authorities, with other membership to be determined locally. The NHS body must ensure it has appropriate clinical advice when making decisions.
- A health and care partnership which might include NHS trusts, public health, local authorities, social care, and community and voluntary organisations. There is little detail on the role or membership of the partnership, with this being left to local discretion. It is expected that guidance will clarify this. The only duty outlined is that the Partnership will be responsible for developing a plan that addresses the wider health, public health and social care needs of the system, and that the NHS body and local authorities should have regard to this plan.

It is currently unclear how these two parts will work together. Governance arrangements will not be set in legislation, leaving ICSs to develop arrangements that work most sensibly for the members.

At place level, organisations will be expected to collaborate, and to develop Integrated Care Partnerships (ICP). Membership of the ICP will not be set in legislation in the same way, leaving how these partnerships operate to be agreed locally.

Underpinning these partnerships, there will be a statutory duty for all organisations across the health and care system to collaborate. Legislation will be removed where it inhibits collaboration and joint decision making so that local authorities can be full partners in both ICSs and ICPs.

A new power will be brought in to limit foundation trust's capital expenditure where they are not working effectively to prioritise capital expenditure within their ICS. The intention is to ensure that system and national spending limits are not breached, whilst capital expenditure is used to best effect across the system, and this power will be used as a last resort where it is felt that an FT is using capital in a way that is not in the best interests of the wider ICS.

Joint committees at both ICS and ICP level will allow for joint decision making, thereby making delegation of powers a reality. In the current arrangements, recommendations on decisions are made at ICS or place level, but decisions can only be made by the Boards of the individual organisations due to the legislative restrictions around joint working between the NHS and local authorities. By developing Joint Committees, these committees can become decision making bodies.

Competition and Procurement

Legislation will be amended to remove barriers to collaboration by removing barriers between NHS bodies and local authorities to enable alignment of decision making and pooling of budgets. The role of the Competition and Markets Authority in decisions on NHS mergers will be removed, although the

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Secretary of State will get new powers to intervene in reconfiguration, and will get powers to create new NHS trusts where structures are inhibiting the best outcomes for whole population health and to respond to emerging priorities. NHS Improvement's role on anti-competitive behaviour will be removed along with its specific competition functions.

ICSs will be responsible for commissioning services currently commissioned by CCGs, and will commission some services currently commissioned by NHS England. A new provider selection regime will be developed, with the ultimate aim that where there is no value in running a competitive procurement process services can be arranged directly with the most appropriate provider.

Ensuring accountability and public confidence

The majority of the proposals in this section relate to national bodies, however there are some potential areas which could affect ICSs, ICPs and trusts:

- The NHS mandate will move from an annual review and renewal to be replaced with a requirement that there is always a mandate in place.
- The Secretary of State will get a new power to intervene in local service reconfiguration changes
- The Secretary of State will have a statutory duty to publish a report in each parliament on workforce planning responsibilities across primary, secondary, community care and sections of the workforce shared between health and social care.
- CQC is expected to have an enhanced role in reviewing system working. The scope of this is still being explored.

Additional proposals

Social care: More fundamental changes to social care are expected to be published later in the year. There are a few changes, however, in this White Paper. The key one is around there being greater flexibility when discharging patients from hospital to a care setting for an assessment, putting in place a legal framework for 'discharge to assess' allowing NHS continuing healthcare and Care Act assessments to take place after discharge from acute care.

Public health: new powers will be introduced to implement comprehensive reciprocal healthcare arrangements with 'rest of the world' countries – i.e. those outside the EEA and Switzerland. This will include the introduction of a reimbursement mechanism, exchange of data to support reimbursement and ensuring that responsibility for paying healthcare charges will lie with governments. There are other provisions around obesity and fluoridation. Additional provisions on public health will be published later in the year.

Safety and quality: The Healthcare Safety Investigation Branch will be put on a statutory footing. DHSC will be given greater powers to amend the governance of professional regulation to ensure the right level of regulatory oversight proportionate to risk. This will include the ability to reduce the number of professional regulators and to introduce regulation of NHS managers and leaders should the need arise, although there is currently no intention to do so. A new statutory medical examiner system will be introduced within the NHS to scrutinise all deaths which do not involve a coroner.

2. Implications for BTHFT

There are implications for BTHFT at every level – trust, place and ICS.

At trust level there are implications as a result of the reducing bureaucracy aspects of the paper. There will be:

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- A new duty to collaborate. Although this is something we have done for several years, there is a new duty on all parts of the health and care system to collaborate. We need to ensure that where we do collaborate with our partners, at place, ICS and through WYAAT, we are doing so at all levels across the trust. This new duty replaces the current duties to cooperate, and the Secretary of State may issue guidance on what collaboration looks like. CQC will have a role in assessing collaboration as part of its inspection framework.
- A new duty to compel providers to have regard to system financial objectives so both providers and the ICS NHS Body are mutually invested in achieving financial control at system level.
- A capital spend limit for Foundation Trusts. This is being introduced in a way that it should not be used, and relates to the overall ICS capital expenditure budget. Where it is deemed that an FT is using capital in a way that might not be in the best interests of the ICS, there is the ability to impose a capital spend limit.
- New minimum standards for good hydration and nutrition in the NHS will be introduced. This will apply to NHS staff as well as patients.

At Place level, there is little in the White Paper to set out working arrangements, leaving it to organisations locally to work out how they will work together. Helen Hirst (Chief Officer, Bradford District and Craven CCG) has taken on the role of Place Lead on an interim basis until April 2022 and will lead the development of the Integrated Care Partnership. A Programme Board reporting to the Bradford District and Craven Executive Board has been set up to oversee this work, and it is anticipated that the ICP will be in shadow form from October 2021. Alongside this, the current Strategic Partnership Agreement is being reviewed to ensure it remains fit for purpose, and by September 2021 the intention is that this will become the underpinning agreement to support the ICP. It is anticipated that the ICP will receive delegated functions from the ICS. This may include some local commissioning functions; this will be worked through the ICP development framework which is being developed by the ICS.

West Yorkshire and Harrogate Health and Care Partnership (our current “ICS”) will be most impacted by the changes. Work is underway to consider the implications of the changes and to put the Partnership in good shape when the new legislation is enacted. There are six workstreams in this programme, all of them were either already underway or planned to start imminently:

- Review of the ICS working model. This is ongoing and considers how the ICS works with provider collaboratives, including WYAAT; and Places, including Bradford District and Craven, to consider relationships and working practices, especially as there will be an expectation of devolved functions with the new legislation
- Producing an ICP development framework which will outline an effective place arrangement and the delegation and accountability arrangements
- Developing new financial arrangements, including how money flows through the system, and contracting and planning approaches
- Developing an approach to system clinical leadership at WY&H and Place levels
- Developing workforce and leadership strategies
- Progressing the Commissioning Futures/strategic commissioning work already underway.

3. Conclusion

BTHFT will need to ensure it is involved appropriately in each of the work programmes outlined above. There is the opportunity now to ensure that the Partnership part of the ICS is a functional body with a real purpose – there is a risk that if it is not created with that purpose it could become superfluous. The

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relationship between the two parts of the ICS will be vital to ensure the smooth running of the whole system. We currently hold two strategic risks on the risk register relating to partnership working, one at place level and one covering WYAAT and the ICS. We will need to ensure that these risks are monitored closely through the development and transition period, and that BTHFT is actively involved in these developments.

Discussions locally have generally welcomed the direction of travel as positive and consistent with the work we have been doing in West Yorkshire in the last 2-3 years, with a focus on collaboration and a permissive approach to allow existing systems to evolve rather than confirm to a central blueprint. Nonetheless there will be some significant risks to manage if we are to realise the ambition of the White paper; these include

- People – inevitable disruption/impact in coming year due to proposed structural changes
- Finance – the need to find a balance between local autonomy versus central oversight
- Bureaucracy – how to avoid simply overlaying new structures on top of old
- Performance management – the tension between too much/not enough, and avoiding hierarchy
- Prescription – holding on to our culture & values etc; these drive improvement more than legislation

Not all of the detail of the autumn engagement document has made it into the White Paper (eg the suggestion that acute trusts could become anchor organisations in place-based arrangements) but that is not to say that they will not be adopted in some way.

There is no formal consultation on this White Paper; DHSC will be carrying out targeted engagement on the provisions prior to publishing the Bill in the next couple of months. Although the White Paper gives a clear signal of intent, not everything outlined here will necessarily appear in the Bill or in the Act which finally receives Royal Assent, and some matters may be dealt with through statutory guidance or other regulatory levers. Depending on the passage of the Bill through Parliament the provisions should be take effect from April 2022.

Recommendation

The Board is asked to **note** the content of the paper.

Risk assessment

Strategic Objective

Appetite (G)

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	Avoid	Minimal	Cautious	Open	Seek	Mature
To provide outstanding care for patients			g			
To deliver our financial plan and key performance targets			g			
To be in the top 20% of NHS employers					g	
To be a continually learning organisation				g		
To collaborate effectively with local and regional partners					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	Low		Moderate	High	Significant	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

Benchmarking implications (see section 4 for details)	Yes	No	N/A
Is there Model Hospital data relevant to the content of this paper?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there any other national benchmarking data relevant to the content of this paper?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Risk Implications (see section 5 for details)	Yes	No
Corporate Risk register and/or Board Assurance Framework Amendments	<input type="checkbox"/>	<input type="checkbox"/>
Quality implications	<input type="checkbox"/>	<input type="checkbox"/>
Resource implications	<input type="checkbox"/>	<input type="checkbox"/>
Legal/regulatory implications	<input type="checkbox"/>	<input type="checkbox"/>
Diversity and Inclusion implications	<input type="checkbox"/>	<input type="checkbox"/>
Performance Implications	<input type="checkbox"/>	<input type="checkbox"/>

Regulation, Legislation and Compliance relevance	
NHS Improvement: (please tick those that are relevant)	
<input type="checkbox"/> Risk Assessment Framework	<input type="checkbox"/> Quality Governance Framework
<input type="checkbox"/> Code of Governance	<input type="checkbox"/> Annual Reporting Manual
Care Quality Commission Domain: Choose an item.	
Care Quality Commission Fundamental Standard: Choose an item.	
NHS Improvement Effective Use of Resources: Choose an item.	
Other (please state):	

Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality	Finance & Performance	Other (please state)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>