

The integration white paper: what you need to know

Key points

- The government has published a white paper setting out proposals that aim to provide better, more joined-up health and care services at ‘place’ level.
- While the white paper largely reinforces existing policy, we broadly welcome 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. The key components of the paper were expected. Arguably, it could be considered a green rather than a white paper as there are several issues that will need further exploration and clarification.
- This is the latest in a long line of white papers and policy documents over recent decades that have tried to better integrate services. The critical question, therefore, is ‘what will this white paper enable which cannot already be done?’ The answer to this appears to be little.
- We had early opportunities to feed into the development of the document and are pleased that some of the more disruptive early proposals under consideration do 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 are reassured, too, that the proposals will not necessitate further primary legislation beyond the existing health and care bill.

- We do, however, have concerns in certain areas. Important questions remain about one of the most notable aspects of the white paper, which is the expectation of a single person accountable for the delivery of a shared plan and outcomes at place level. This proposal would not change the formal accountable officer duties within local authorities or those of the integrated care board chief executive. This has the potential to create a confusing landscape of individuals with overlapping responsibilities for the same populations. It is also not clear how the new accountable individuals at place will be held to account, including by the public.
- Another concern about the single accountable person is that the individuals in question will not be given any formal levers to exert influence over health and care budgets and commissioning. This will pose a difficult challenge for accountable individuals in areas where relationships between health services, social care providers and local authorities need to be improved.
- There is unanimous support for the aspiration to deliver an integrated workforce to improve patient experience and outcomes. However, most of the workforce proposals set out in the white paper are not new and repeat what was in the adult social care reform white paper. They do not acknowledge or address the fundamental shortages of people working in all parts of health and social care. We cannot apply 'quick fixes' to a major structural problem: severe workforce shortages across health and care.
- By contrast, we are clear that long-term investment is needed to increase training places for health and care professionals, and address the pay, terms and conditions gap between health and social care. Without this, there is only so much that ICSs will be able to do

to improve working culture for health and care staff and deliver better services. We expect this to have significant long-term implications for the integration agenda.

- Another notable issue missing from the white paper is any mention of integrated working below place and at ‘neighbourhood’ (or ‘locality’) level. There are ongoing discussions across health and care on what integration should look like in this more local setting. It could be where primary care takes the lead. In counties, which are coterminous with places, there could be devolution to the district councils that hold responsibility for providing key services that influence population health. The white paper does little to address this.
- Finally, there are other important component parts of the ICS landscape that are barely mentioned throughout the paper, but which will need to work closely with health and care services at place level. For instance, systems across the country are developing arrangements for how provider collaboratives will engage with place-based partnerships. While we would resist national prescription, some basic expectations of how provider collaboratives and place-based partnerships should interact and how overlapping accountabilities between the two can be managed would be helpful.
- The white paper concludes with a set of questions for consultation. Over the coming weeks, we will engage with our members to develop a more comprehensive response to the detail of the white paper.

Overview

The integration white paper focuses on integration arrangements at place level and aims to accelerate better integration across primary care, community health, adult social care, acute, mental health, public health and housing services which relate to health and social care. Children's social care is not included within the scope of the paper, and it is left to places to consider the integration between and within children and adult health and care services.

Overall, the document, published on 9 February 2022, is not prescriptive and permits a good degree of local flexibility. It covers:

- **Governance.** All places will be required to adopt a governance model by spring 2023. This must include a clear, shared plan against which delivery can be tracked and which should be underpinned by pooled and aligned resources.
- **Leadership.** The paper states that there should be a single person accountable for the delivery of the shared plan and outcomes in each place or local area. This may be, for example, an individual with a dual role across health and care or an individual who leads a place-based governance arrangement. The single person will be agreed by the relevant local authority or authorities and integrated care board. These arrangements should, as a starting point, make use of existing structures and processes including health and wellbeing boards and the Better Care Fund.
- **Budget pooling.** NHS and local government organisations will be supported and encouraged to do more to align and pool budgets. The government will review existing pooling arrangements (such as Section 75, NHS Act 2006) with a view to simplifying the regulations for commissioners and providers across the NHS and local government to pool their budgets. The paper states that this will continue to be subject to both NHS and local authority partners agreeing locally what constitutes fair.

There is an expectation that financial arrangements and pooled budgets will become more widespread and grow to support more integrated models of service delivery, eventually covering much of funding for health and social care services at place level.

- **Oversight.** Following further work with stakeholders, the government will set out a framework with a small and focused set of national priorities and an approach from which places can develop additional local priorities. This will come into force in April 2023. Local leaders will be responsible for working with partners to develop their priorities. National priorities will be formulated in a way that prevents overlap with existing regulatory/oversight regimes and with a focus on outcomes rather than outputs. Local partners and integrated care systems (ICSs) will be responsible for identifying and addressing issues and barriers to delivery. Regulators will play a key role in overseeing the planning and delivery of these outcomes.
- **Digital.** ICSs will be required to develop digital investment plans for **bringing all organisations to the same level of digital maturity**. The Department of Health and Social Care (DHSC) will take an ‘ICS first’ approach to supporting integration, encouraging organisations within an ICS to use the same digital systems and providing care teams working across the same individual’s pathway with accurate and timely data.

Every ICS will need to ensure that all constituent organisations have a base level of digital capabilities and are connected to a shared care record by 2024, enabling individuals, their approved caregivers and their care team to view and contribute to the record.

- **Workforce.** ICSs will be required to support joint health and care workforce planning at place level, working with both national and local organisations.

The paper outlines the intention to introduce integrated skills passports. This will: enable health and care staff to transfer their skills and knowledge between the NHS, public health and social care; increase nurse training opportunities in social care settings; and focus on roles which can support care co-ordination across boundaries, for example

link workers. DHSC will increase the number of healthcare interventions that social care workers carry out by developing a national delegation framework of nursing interventions.

More broadly, regulatory and statutory requirements that prevent the flexible deployment of health and social care staff across both sectors will be reviewed. Funding will be provided to deliver [Care Certificates](#), alongside significant work to create a delivery standard recognised across the social care sector.

Analysis

Broadly, the white paper aligns with the direction of travel already set out in the health and care bill. We are reassured that local flexibility remains at the heart of the proposals, with strong scope for local decision-making.

Further, it is welcome that the government has addressed some of the key concerns that we have made throughout the development of the proposals. Firstly, the government has not made pooled health and care budgets beyond the Better Care Fund mandatory. While there is potential for pooled budgets to improve the integration of services, this should remain at the discretion of local health and care leaders. The biggest barrier to further pooling of budgets remains long-term underinvestment in local government, not the limitations of existing mechanisms such as section 75 of the NHS Act 2006.

Second, the white paper includes a welcome focus on outcomes not outputs. Shared outcomes across different ICSs will need to be designed by partners across the system and with citizens, grounded in shared insight and understanding of the needs of the population. We pushed strongly for a consultative and locally driven approach to outcomes frameworks, and are encouraged that this is reflected in the final document.

Despite these positives, this is the latest in a long line of white papers and policy documents over recent decades that have tried to better integrate services. The critical question, therefore, is ‘what will this white paper enable which cannot already be done?’ The answer to this appears to be little.

We also have concerns on several key elements, particularly relating to the single person accountable for the delivery of outcomes at place and the absence of what is needed to make integrated workforce planning a reality. While we are broadly supportive of this in theory, there are many practical challenges still to work through. In addition to those already outlined in the key points section, it is unclear how this single accountable person could operate within the variety of place-based arrangements

permitted by NHS England and NHS Improvement. For example, how could this work in areas where place-based commissioning is devolved to a provider collaborative by the ICB, as suggested in the ICS Design Framework?

We knew that the single accountable person would be selected by local partners, but the final version of the white paper clarifies that ‘this person will be agreed by the relevant local authority or authorities and the ICB’. This makes sense given that the individual will be responsible for promoting integration between health and care. However, there may be a case at least for some consultation on the selection process and candidates among a broader selection of stakeholders, for example across primary care, the voluntary, community and social enterprise sector and the public.

Finally, it is disappointing that children’s care services are considered outside the scope of the white paper. Given the importance of early years development, health and wellbeing to wider population health this is a glaring omission from its scope.

In detail

More specific feedback for each section of the white paper, which we will take to DHSC, is set out below.

Shared outcomes (Section 2)

- While we await the detail of this process, we welcome the fact that the white paper sets out a consultative approach to developing and agreeing shared outcomes. This, helpfully, includes a role for citizens in contributing to the detail of agreed outcomes for their own area (p.25). We plan to engage widely with our members on this issue and would welcome close involvement so that outcomes adopted are supported by ICSs.

- It is welcome that the white paper refers to ‘a framework with a concise number of national priorities from which places can identify additional local priorities’. We will hold the government and NHSEI to account on this commitment, as our members have for a long time argued for a reduction in the amount of nationally-driven priorities. Recommendations on this will be made in our forthcoming report on the role of the centre in a systems world, led by Sir Chris Ham.
- The white paper states that the shared outcomes framework (including scope for local input) will be published by spring 2023. It then argues that the implementation of shared outcomes will ‘go live from April 2023’. (p.36) This leaves very little time for systems to develop and align their own local priorities with those set nationally and prepare for delivery of the framework. We would urge the government to revisit these timelines.
- As well as the number of national priorities, the nature of reporting against these priorities will be significant in terms of how they land with NHS leaders. We expect to work further with the government and NHS England and NHS Improvement to ensure that both system and place leaders are not ‘bogged down’ by reporting and quality assurance commitments.
- We are concerned to see that the overarching commitment from the NHS to be the world’s first net zero health system has been omitted from the paper. Responding to the universal threat of the climate change is the responsibility of the whole health and social care system. A shared outcomes framework must reflect services and care which have been designed with the national priority of reducing carbon emissions for the health and wellbeing of local people and populations.

Leadership, accountability and finance (Section 3)

- We are broadly supportive of a single accountable person for the delivery of the shared plan and outcomes for the place (p.11, 33). However, there may be a challenge in having one person accountable

amid the variety of place-based arrangements that have been permitted by NHSEI. For example, how could this work in areas where place-based commissioning is devolved to a provider collaborative by the ICB, as suggested by the ICS Design Framework? We will continue to make clear that our members expect to be involved in conversations about how this would work in practice.

- 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 lacks resilience as it is vulnerable to change in leadership, and is not universal’ (p.26)

It is not, however, clear what (if any) new levers the white paper is introducing for the new accountable individuals at place. This will pose a challenge for accountable individuals in areas where relationships between health services, social care providers and local authorities require improvement.

- We welcome that pooled budgets between health and care will not be made mandatory beyond the Better Care Fund. We would, however, welcome further clarity on what is meant by the following wording:

‘In some cases, particularly as arrangements at place mature, it may well make sense to put in place more formal pooling arrangements, and **we would expect the overall level of pooling to increase in the years ahead.**’ (p.37) (emphasis added)

- While we have welcomed the recent real-terms increase on spending for the NHS, social care remains underfunded. The health and care levy has done little to increase the net overall spend on social care. There is therefore a risk that by leaning heavily on the NHS to pool budgets, the NHS budget is stretched too thin to make up for a shortfall in local authority funding.
- We are pleased to see the final version of the white paper reflect a revised date of spring 2023 for when all places within an ICS should

adopt a clear governance model (p. 33). We will consult our ICS members on whether this timeline is achievable.

- The government's initial position paper on the integration white paper referred clearly to the principle of subsidiarity. It is unfortunate that this is not referred to at all in the final wording.

Oversight and support (within Section 3)

- It is encouraging that the Care Quality Commission and other regulators will be required to consider the planning and delivery of outcomes agreed at place level as part of their assessment of ICSs. Local leaders are best placed to set the priorities of the local populations they serve.
- We also welcome the government's focus on preventing duplication of oversight/regulation by reviewing alignment with other priority setting exercises and outcomes frameworks across the health and social care system as part of the shared outcome setting process.
- The white paper helpfully elaborates on the prospective role of the CQC in system regulation/oversight, stating that it will consider outcomes agreed at place level as part of its assessment of ICSs. All regulators, including NHSEI and professional regulators will need to ensure their frameworks for regulation/oversight support integration and grapple with the complexity of the different levels of accountability within an ICS – from the ICB and ICP, to providers, local authorities and now right down to the local leader at place – as well as the interplay of the national and local priorities. The government should take a permissive approach in allowing regulators to develop their new frameworks
- Regulators should also consider the role of ICB level peer review, which could offer a more robust assessment of integration and partnership working and indeed what good looks like in terms of progress towards local outcomes.

Digital and data (Section 4)

- We welcome the commitment to ensuring all organisations meet a minimum level of digital maturity. 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 made possible.
- We need to see clear routes of funding from an easy-to-navigate stream which systems can access. There is a need for transparent and clear procurement frameworks.
- 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.

Workforce (Section 5)

- Members are concerned to ensure that the commitment to integrated workforce planning is taken forward meaningfully with partners across the ICS. We welcome the steps that HEE is taking to support this work, but also know that there are further opportunities for it to establish a national system for workforce planning in systems which does not rely on relatively expensive offers from management consultants. Through our NHS Employers team we are working with the Local Government Association and Skills for Care to identify principles and good practice to support this approach. We also continue to be clear that a comprehensive and published workforce plan for social care and health is needed, which must be ultimately rooted in the assessments and analysis provided by systems.
- The white paper is silent on the scale of vacancies across all parts of the system, amid growing levels of demand. It does not address the

disparity between the workforce conditions and pay rates between health and social care staff.

- The paper does, however, include a focus on training and development for staff, particularly in social care, new roles and to an extent workforce planning. This is welcome. Additional competencies for social care staff are possible but questions need to be answered around whether there are pay implications, and how 'new' tasks will be identified.
- We welcome the focus on placements in social care. There is scope to expand placement and training opportunities across all parts of the sector. Demand for healthcare training is high. To leverage this interest requires additional capacity for training and placements, including diversifying the types of places where people can be trained in the community, primary care, social care, the independent and voluntary sector.
- We must also explore opportunities to scale up evidence-based approaches to virtual and augmented reality learning, where relevant. This will need **significant investment in training infrastructure and supervision capacity**. If we can achieve this, we envisage not only increasing the UK supply into employment, but it can also act as an enabler to delivering care differently.

Key actions for members

Several expectations are set out for members, especially ICSs, throughout the white paper. These include:

By June 2022 digital investment plans should be finalised which include the steps being taken locally to support digital inclusion.

By Spring 2023, places are expected to adopt a model of accountability, either the one developed by the DHSC or an equivalent, with a clearly identified person responsible for delivering outcomes, working to ensure agreement between partners and providing clarity over decision making.

By 2024, each ICS must have a functional and single health and adult social care record for each citizen.

By 2024, every ICS will need to ensure that all constituent organisations have a base level of digital capabilities and are connected to a shared care record, enabling individuals, their approved caregivers and their care team to view and contribute to the record.

To achieve 80 per cent adoption of digital social care records among CQC-registered social care providers by March 2024, ICSs must work with partners to drive adoption.

By 2025, each ICS will implement a population health platform with care coordination functionality that uses joined up data to support planning, proactive population health management and precision public health.

By 2026, all local areas should work towards inclusion of services and spend.

How we will be supporting members

The white paper concludes with a set of questions which DHSC will be engaging on with stakeholders. These include many relating to the areas covered above, including outcomes, accountability and workforce. Building on the initial positions set out in this briefing, the NHS Confederation will engage broadly across our networks to ensure that our members' voices are represented to DHSC through this engagement process.

On oversight and regulation, we will also be working closely with regulators to ensure that regulatory frameworks are supportive of our members. As part of this work, we will shortly be publishing a set of principles to guide the first year of system regulation.

Should you wish to share any concerns or comments on the white paper directly with us, then please contact william.pett@nhsconfed.org

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