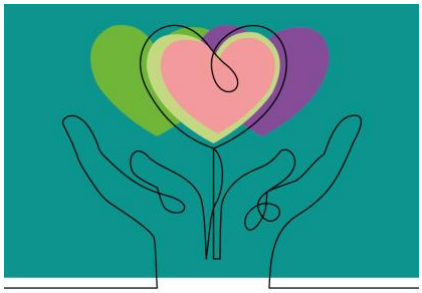

The Health Devolution Commission
Briefing for Lords' Second Reading of Health and Care Bill:
A Real Opportunity to Level Up Health

Executive Summary

The cross-party, cross-sector Health Devolution Commission has published a number of reports[1] on why and how reform of health and care is needed including its original report 'Building Back Health and Prosperity' and, more recently, 'Levelling Up Health' on proposals for ensuring a genuine levelling up in the system between National and Local Government; between the NHS, social care and public health; between physical and mental health; and between treatment and prevention.

The Health and Care Bill published on 6th July 2021 will complete its passage through the Commons on 24th November and will have its Second Reading in the Lords in early December 2021. The Commission believes the Bill has the potential to transform the way that our health and social care system works to both improve the quality of health and social care services ***and*** to improve the health of the population and reduce health inequalities.

However, following debate of the Bill in the Commons, the Commission believes that the potential to build the NHS of the future will only be realised if the Bill is strengthened in the Lords in three key areas:

1. **Provide an explicit focus on reducing health inequalities** in communities as well as delivering better, more integrated health and social care services.
2. **Create a genuine partnership of equals** between the NHS and Local Government to deliver person-centred care and improve population health
3. **Establish place-based partnerships** as the building blocks for delivering the system-wide goals of an integrated care system including pooled budgets and provider collaboratives

Additional issues that the Commission has raised previously and which remain a concern are:

4. **Support for the social care workforce**: The Bill should include a requirement on Government to publish a Social Care People Plan that, in the longer-term could become part of a national Health and Social Care workforce strategy that is reviewed every two years, not five.
5. **Parity of esteem for mental health**: There is an opportunity for the Bill to enshrine in legislation parity for mental health services. The Bill should also stipulate that Integrated Care Boards include a representative of mental health providers
6. **Support for health and care social enterprises**: The Bill should explicitly recognise the key role that the VCSE sector will play in Integrated Care Systems, placed-based partnerships and provider collaboratives.

[1] See https://healthdevolution.org.uk/

Prepared by Phil Hope and Steve Barwick

The Government has also announced its intention to publish two further White Papers - on Adult Social Care and Integration - whilst the Bill is under consideration by Parliament. The Commission believes these policy proposals should have been produced before the Bill was published and that, depending on the changes proposed, proposals to transform the provision and funding of social care and public health should be included within the Bill. Furthermore, the proposed inspection of the performance of local authorities in discharging their 'regulated care' function to give added assurance and oversight about social care should not be introduced ahead of the White Paper on Social Care.

This briefing by the Health Devolution Commission for Members of the House of Lords takes account of issues raised in the Commons and highlights six key issues that should be raised during further detailed examination in the Lords. It draws upon the Bill and the accompanying Explanatory Notes, and the ICS Design Framework published by NHSE in June 2021 and Thriving Places in September.[2] If Peers would like further information or clarification or want to meet to discuss any of the issues raised here, please contact steve@devoconnect.co.uk

Please note that although the Health Devolution Commission is kindly supported by a wide range of organisations – see list at end page 7 - this briefing does not represent the specific or comprehensive viewpoint of any one of them.

1 REDUCING HEALTH INEQUALITIES

The proposed 'Triple Aim' duty on the NHS to 'consider the effects of their decisions on the better health and wellbeing of everyone, the quality of care for all patients, and the sustainable use of NHS resources'[3] is welcome as it clearly goes beyond the delivery of better health services to encompass the crucial goal of improving the population's health. However, the 'Triple Aim' still does not go far enough and must explicitly include the aim of reducing health inequalities:

- The Commission believes that **reducing health inequalities** should be explicitly included within the wording of the 'Triple Aim' in the Bill if serious progress is to be made in achieving this goal. Tackling health inequalities will need the NHS to clearly demonstrate and secure the local economic and social benefits of all its investments and work collaboratively with Local Government and the voluntary sector; it will need national bodies to make sure that the reduction of health inequalities sits at the heart of the performance and oversight system; and it will need a well-resourced support programme to help local areas make the changes to service delivery and to their engagement with local communities, including their role as anchor institutions.

- Crucially, the explanatory notes to the Bill say that 'integrated care boards must, in the exercise of their functions, have regard to the need to reduce inequalities between patients in relation to their ability to **access health services** and in the outcomes achieved from **health services**'. This narrow interpretation must be widened to include the NHS having regard to reducing health inequalities within the population as a whole not just through its services including the need to address long-standing racial disparities in health outcomes.

- The broader 'Triple Aim' duty that cements reducing health inequalities as the guiding light for the NHS should apply to both the Integrated Care Board and the Integrated Care Partnership as the dual statutory structures within each Integrated Care System. The Board and the Partnership should develop clear criteria for evaluating jointly the ICSs' success in achieving the broader 'Triple Aim' including reducing health inequalities in both service delivery and the health of the local population.

[2] https://www.england.nhs.uk/publication/integrated-care-systems-design-framework/
[3] Health and Care Bill Explanatory Notes

2 INTEGRATED CARE SYSTEMS: A PARTNERSHIP OF EQUALS

The Bill should make clear that the NHS and Local Government are viewed as equal partners in Integrated Care Systems, working together equally, as described in the NHSE ICS Design Framework, to produce both the Partnership's health and wellbeing strategy for their area, and the Board's forward plan for contributing to making this strategy a reality.

This is the approach already being taken on the ground by many Integrated Care Systems building on strong personal relationships among system leaders. However best practice is not always followed by all and some reassurance is therefore sought in Second Reading that inherent tendencies towards NHS dominance as well as centralisation not decentralisation will not prevail and each ICS will be a genuine partnership of equals.

Relationship between the Board and the Partnership:

- Each Partnership will be tasked to develop a **joint local health and wellbeing strategy** detailing how the health, social care and public health needs of its area will be met by either its Board, NHS England or its local authorities. The Board with its partner NHS Trusts and Foundations Trusts is required to produce **a five year forward plan** setting out how it will meet the health needs of its population including primary, community and acute care. All published forward plans must include a statement as to whether the relevant Health and Wellbeing Board(s) have agreed that the Board plans have due regard to the Partnership health and well-being strategy or strategies.

- It should be made more clear what it means for an Integrated Care Board to 'have regard' to the strategy produced by the Integrated Care Partnership. The problem with 'have regard to' is that it means the ICP strategy can be considered and rejected. An alternative discussed by the Commission is to amend the wording so that there is an obligation on the ICB 'comply with' the ICP strategy. This however, could imply a hierarchy and not a partnership of equals. A further alternative suggested by the Commission is that the Bill should say there must be "clear and demonstrable alignment" between the ICP strategy and the ICB plan.

Board and Partnership Chairs:

- Most ICSs have now chosen their Integrated Care Board Chair Designate (to be ratified once the Bill becomes law) using the proposed detailed regulations on the nature and process in the Bill. The Commission believes that these appointments should be for two years only; that the process should be reviewed to assess the risk of potential conflicts of interest where a chair is a person seconded from an NHS organisation such as a large NHS or Foundation Trust rather than an independent person as described in the NHSE ICS Design Framework[4]; and that ICB Chairs in future should be appointed locally and jointly by the NHS and Local Government partners without involvement from the Government. The Bill should also include a provision that a democratically elected council leader – or Metro Mayor where ICS and Combined Authority geographies align – could be a vice-chair of the ICB.

- There is no guidance in the legislation on the Chair and membership of the Integrated Care Partnership. This flexibility for local determination is welcome but there should be a presumption in the guidance that the Partnership Chair is a Local Government leader or metro mayor as agreed among local partners to ensure visible local democratic and accountable leadership within the Integrated Care System.

[4] ICS Design Framework https://www.england.nhs.uk/wp-content/uploads/2021/06/B0642-ics-design-framework-june-2021.pdf

3 INTEGRATED CARE SYSTEMS: DELEGATION TO PLACE-BASED PARTNERSHIPS

The Bill will allow Integrated Care Boards to exercise their functions through place-based committees described in their legally required constitutions, but will remain accountable for them to the NHS. The ICS Design Framework[5] goes further and provides more detail: 'ICSs will have the freedom to set a delegated budget for place-based partnerships … and should engage local authority partners on services to be commissioned at place and support transparency on the spending made at place level. It should explain any variation from previous CCG budgets and enable the shared planning or pooling of NHS and local authority budgets, including stated minimum NHS contributions to Better Care Fund arrangements.'

The Health Devolution Commission is clear that 'place-based partnerships' based on the principle of subsidiarity and co-terminous with the footprints of councils with adult social care responsibilities (with flexibility for local variation where agreed), should be the fundamental building blocks of Integrated Care Systems, and the principal level at which integration, and delivery of services, should be taken forward.

- **Purpose:** The purpose of place-based partnerships should be clearly specified in the legislation to include improving population health and reducing health inequalities, as well as delivering integrated health and social care services.

- **Decentralisation:** The Government should make clear its support for decentralisation, and that every ICS should establish place-based partnerships co-terminous with councils with adult social care responsibilities, governed by place-based committees, and with delegated powers and resources to deliver integrated health, social care and public health services. There should be reserve powers for NHSE to intervene if place-based partnerships are not in place after a suitable period of time.

- **Accountability:** The Secretary of State should **not** have the power to intervene in any local decisions of an ICS unless there is a clear breach of the NHS mandate or constitution. The Government should make clear its expectations on the accountability of place-based partnerships to the integrated care board and partnership in ways that respect the principle of decentralisation. Any new national accountability mechanism for ICSs or place-based partnerships should build on and enhance existing local democratic accountability, not bypass or undermine it. The Health Devolution Commission supports the Amendment proposed by the NHS Confederation and tabled by Lord Victor Adebowale.

- **Place-based budgets**: Place-based, whole population, joint health, social care and public health budgets for a place should be actively promoted by the Government as the norm in every system.

- **Provider collaboratives**: The Bill's replacement of competition with collaboration as the organising principle for the procurement of clinical healthcare services is welcome, as is the creation of provider collaboratives – the formal bringing together of all bodies delivering NHS services for this purpose. However, there is a risk that these new organisational forms will be too narrowly focused on a medical model of care, and on only part of a local care pathway, frustrating efforts to deliver fully integrated care. To reduce this risk, ICSs should delegate their budgets to place-based committees, and ensure that provider collaboratives are full members of each relevant place-based committee, participating alongside Local Authorities in joint service planning, commissioning and pooling of budgets. This would also address concerns raised by some regarding the potential for privatisation.

[5] Thriving Places https://www.england.nhs.uk/wp-content/uploads/2021/06/B0660-ics-implementation-guidance-on-thriving-places.pdf

- **Transparency**: The process of awarding service contracts to clinical healthcare service providers through place-based committees should be made transparent, and open to scrutiny and challenge, to ensure patients receive the best quality services from provider collaboratives.

4 THE WORKFORCE

The Bill will set out a duty on the Secretary of State to publish, at least once every five years, a report describing the system in place for assessing and meeting the workforce needs of the health service in England. However, this will not include the social care workforce which is similar in number to the NHS workforce (around 1.5 million people) and delivers care and support to people in need, many of whom receive health care too. The Commission believes that this is a missed opportunity to recognise and enhance the value and role of the care workforce in local integrated care systems.

- **The Jeremy Hunt amendment**: This would have meant that 'at least every two years the Government must lay a report before Parliament describing the system in place for assessing and meeting the workforce needs' of the health and social care sector. It was defeated by 61 votes at the Bill's Third Reading in the House of Commons. The Health Devolution Commission supporters would expect, and would support, it being re-tabled in the Lords either at Second Reading or in a Committee of the whole House.

- **The social care workforce**: The Health Devolution Commission proposes workforce provisions in the Bill go further. For example, the development of the social care workforce should be described in workforce plan to be published by the Government every 2 years. This should be in the form of a Social Care People Plan and Promise that mirrors the NHS People Plan and Promise as proposed by the cross party, cross-sector Future Social Care Coalition[6]. This is an urgent first step towards the long-term goal of a single Health and Social Care People Plan published every two years.

- **The ICS workforce**: The ICS Board and Partnership should be required in the legislation to develop a joint plan for the development of the health and social care workforce in its area.

5 Mental Health

There is little in the Bill specifically about mental health services but reforms to the Mental Health Act are expected in a separate, later Bill. However, the Health and Care Bill provides an important opportunity to legislate for the *principle* of parity of esteem between physical and mental health services and to deliver parity in *practice* through the inclusion of formal representation of mental health providers on the IC Board as well as those charities and social enterprises who promote greater awareness of mental health services on the IC Partnership.

Improving the public's mental health and delivering modern mental health care depend on a well-functioning and equal partnership between the NHS, local councils, communities and a range of other agencies. The Health and Care Bill is an opportunity to embed recognition of the value of mental health in delivering the aims of integrated care systems; to ensure the integration of mental health services and physical health services are a key task for the IC Board; and to make clear the leadership role of IC Boards in developing better mental health services.

[6] https://futuresocialcarecoalition.org/wp-content/uploads/2021/06/Final-FSCC-A-Social-Care-People-Plan-Framework-1.pdf

Parity of esteem for mental health: Many ICSs will properly prioritise mental health and take forward this agenda in line with their responsibility for implementing many aspects of the NHS Long Term Plan, including the expansion of community mental health services. However, there is nothing in the Bill that ensures mental health will be given equal precedence with physical health in all integrated care systems.

For example, the Bill provides little reassurance that Local Government services such as public health (including drug and alcohol treatment) and social care will have equal standing with NHS services. The Government should reinforce its support for parity of esteem between mental and physical health to help prevent mental health being marginalised by some integrated care systems and Boards.

Integrated mental and physical health care: Too often, people experience mental health care as dis-integrated, especially from physical health care. Fragmented services are especially commonly cited as a concern for people of all ages with 'complex' needs that require support from more than one agency at a time. Bringing support together and encouraging collaboration rather than competition between public services may help to reduce some of the fragmentation and gaps people face. The Centre for Mental Health has said "The idea of integrated care has many potential benefits for both the public's mental health and for mental health services" however these benefits may not be universally realised without specific reference to mental health in the legislation and representation of mental health on the IC Board.

Leadership and resources for mental health: Integrated Care Systems should take the lead in improving the level of resources to be spent on mental health care, determining what services are funded and establishing who should provide them. This is of increasing importance given the evidence from the IFS, the Resolution Foundation and BACP regarding the chronic, wide-ranging and long-lasting 'mental health pandemic' precipitated by Covid-19. The Government should make clear its expectation that ICSs will give priority to improving the populations mental health, not just physical health, and to improving and integrating mental health care services in their area.

6 THE VOLUNTARY, COMMUNITY AND SOCIAL ENTERPRISE SECTOR

The NHSE ICS design framework includes a clear and welcome description of the key role of the VCSE sector in the new system:

> 'The VCSE sector is a vital cornerstone of a progressive health and care system. ICSs should ensure their governance and decision-making arrangements support close working with the sector as a strategic partner in shaping, improving and delivering services and developing and delivering plans to tackle the wider determinants of health. VCSE partnership should be embedded as an essential part of how the system operates at all levels. This will include involving the sector in governance structures and system workforce, population health management and service redesign work, leadership and organisational development plans.'

The Bill includes a new legal mechanism that will allow ICBs and NHS providers to form joint committees, to make joint arrangements and to pool funds; and these should include representation from other bodies such as primary care networks (PCNs), GP practices, community health providers, local authorities and the voluntary sector. The explanatory note says that the VCSE sector can be invited to be members of integrated care partnerships, and VCSE staff should be included within Primary Care Networks as suggested in the NHSE ICS design framework.

The Government should make clear its support for the key role that the VCSE sector plays in Integrated care Systems, placed-based partnerships and provider collaboratives. The system should avoid provider collaboratives being dominated by large hospital providers, and enable small statutory and VCSE sector health service providers to be treated as equal partners in provider collaboratives and place-based committees where they can add most value for patients.

The Commission is particularly concerned that the reforms may have specific and serious unintended consequences for not-for-profit health social enterprises wholly funded by the NHS to deliver a wide range of vital community health services. Health organisations of this type are not referred to in the Bill and there appears to be little, if any, recognition of the potential impact of the new structures of provider collaboratives and place-based partnerships on their funding or involvement in decision-making.

- **Health Social Enterprises**: The Commission believes greater recognition of the unique status and added social value that health social enterprises can bring to local health and care systems to avoid the unintended impact of jeopardising the viability of health social enterprises in the way that the new structures will operate to commission health services.

- **Value of the VCSE sector**: The Government should make clear its support for the NHSE view of the value of the VCSE sector as a whole in integrated care systems and reflect this more clearly in the legislation.

- **VCSE Concordat**: The Government should support the principle of each ICS developing a VCSE Concordat describing how integrated care boards will invest in and support the sector, to enable it to play its part in delivering better care and reducing health inequalities including the option of a VCSE Alliance as suggested by NHSE in its ICS design framework.

Please note that although the Health Devolution Commission is kindly supported by a wide range of organisations – see below - this briefing does not represent the specific or comprehensive viewpoint of any one of them.

The partners of the Health Devolution Commission are NHS Confederation, LGA, London Councils, Social Enterprise UK, the Northern Health Science Alliance, the British Association of Counselling and Psychotherapy, Greater Manchester Health and Social Care Partnership and West Yorkshire and Harrogate Health and Care Partnership.

November 2021 Phil Hope and Steve Barwick, the Health Devolution Secretariat