**Notes on the White Paper ‘Health and social care integration:**

**joining up care for people, places and populations’**

(Department of Health and Social Care, updated February 2022)

<https://www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations/health-and-social-care-integration-joining-up-care-for-people-places-and-populations>

**1. Summary of key proposals**

(Based on the Local Government Association’s summary in its response to the White Paper, with additions from NHS Providers: see Appendices 1 and 2).

The White Paper sets out a new approach by the government aimed at bringing together the NHS and local government to jointly deliver health and care services to local communities. It involves:

* consulting stakeholders and setting out a framework for shared outcomes to be implemented by Spring 2023.
* expecting by Spring 2023 that all ‘places ‘adopt a model of accountability and determine responsibilities for decision-making, including how services should be shaped.
* requiring a single accountable person to be identified at place level for delivering shared outcomes – possibly an individual with a dual role across health and care or an individual lead of a ‘place board’ for example.
* publising guidance on the scope of pooled budgets in Spring 2023 and review section 75 of the 2006 Act which underpins pooled budgets, to “simplify and update” the regulations allowing transfers or pooling of funding between NHS commissioners and local authorities.
* working with “partners” to develop guidance for local authorities and the NHS to support going further and faster on financial alignment and pooling.
* requiring “asignificant and, in many cases, growing proportion of health and care activity and spend” to be overseen and funded through the place-based partnership.
* setting out the policy framework for the Better Care Fund from 2023, including how the programme will support integration at place level.
* working with the Care Quality Commission (CQC) and others to ensure the regulation regime supports the new shared outcomes and accountability arrangements at place.
* developing a national leadership programme, addressing the skills needed to deliver system transformation and place-based partnerships.
* ensuring all professionals have access to a single health and adult social care record for each citizen (by 2024), ultimately accessible by citizens.
* ensuring each ICS will implement a population health platform that uses joined up data to support planning, proactive population health management and public health (by 2025).
* developing a standards roadmap (2022) and co-designed suite of standards for adult social care (Autumn 2023).
* enabling one million people to be supported by digitally enabled care at home (by 2022).
* strengthening the role of workforce planning at ICS and place levels.
* reviewing barriers (including regulatory and statutory) to flexible movement and deployment of health and care staff at place level.
* developing a national delegation framework of appropriate clinical interventions to be used in care settings.
* improving opportunities for cross-sector training and joint roles for adult social care and NHS staff in both regulated and unregulated roles.
* appointing a set of front-runner areas in Spring 2023 to trial the outcomes, accountability, regulatory and financial reforms discussed in this document.

**2. Our general observations**

The White Paper is highly repetitive, aspirational and without concrete proposals for how to deal with practical / legal problems or issues.

The overall concern is with prevention, ‘wellbeing’, and population health.

It suggests a much greater role for ‘places’ rather than at a strategic level (the ICS), saying that “The truly radical possibilities ….. are more likely to be identified and realised by local organisations than through central prescription.”

Eventually, pooled or aligned budgets will cover much of the funding for health and social care services at place level. This is a significant example of where the practical / legal issues are barely addressed.

The White Paper refers to ‘partners’, e.g. on the place board, without clarifying whether these can include representatives from the private sector.

The proposals strongly reaffirm the government’s commitment to personal health budgets, personal budgets and integrated personal budgets as a means of integrating services for individuals.

Significantly, although the Health and Care Bill, if passed, makes ICS ICB and ICP statutory bodies, ‘places’ will not of themselves have statutory authority. They may undertake statutory functions delegated by the ICS’s statutory bodies, but places will also be able to take on “a significant amount of system decision-making” in their own right.[[1]](#footnote-1) Significantly, the Bill does not set out fixed arrangements for the governance of place-based working.

The ICP is mentioned only three times in the White Paper, and only then in passing.

**3. The main issues**

**3.1 Places**

All local areas will be expected to make place-based arrangements to integrate NHS and local authority (LA) working. Responsibilities at place level will include the commissioning and delivery of health and care services, agreeing shared outcomes (i.e. in addition to nationally set outcomes) and being accountable for these outcomes.

Although the strategic level is said to remain at ICB level (or what the White Paper often refers to as ICS level), “places will be the engine for delivery and reform.” That said, there is a significant lack of clarity about

a) the accountability for decision making at place level, and

b) how the different focus and responsibilities of local authorities and the NHS can be integrated at place level.

In addition, the White Paper omits any mention or clarification of the role of private providers at place level.

NHS Providers are concerned “that, by setting national expectations at place level, the white paper risks cutting across the bill and role of ICSs.”

*a) Governance and accountability*

Placeswill be able to decide which accountability model to adopt but the WP provides the ‘place board model’ as an example. This brings together ‘partner organisations’ to pool resources, make decisions and plan jointly. A single person will be accountable for the delivery of shared outcomes and plans, working with local, unspecified ‘partners’.

In this model, the statutory LA and ICB (no mention of the ICP) jointly agree and delegate their functions to “an integrated health and social care board at place,” with a single point of accountability. This board will fund and commission the full range of health and adult social care services.

There is no explanation of where the membership of this board will come from, or the criteria for appointing the single accountable person who could be “an individual with a dual role across health and care, or an individual who leads a place-based governance arrangement”).

Significantly, it’s unclear how an ICS’s different “integrated health and social care boards at place” (of which there could be as many as 10, as in the case of Greater Manchester, or even more) will work together - for instance how they are to resolve conflicts of interest. The White Paper only says that, whatever governance model is chosen, it must provide clarity of decision-making covering, for example,

* contentious issues, such as reshaping services within the place (and contributions to wider decisions such as reconfigurations across a wider geography) and
* clear, practical arrangements for managing risk, resolving disagreements between local partners, and for agreeing the outcomes to be pursued locally in addition to any set nationally, with strong involvement of the health and care provider organisations for that place.[[2]](#footnote-2)

NHS Providers has clear concerns about the proposals, saying:

“ It is very striking how many trust leaders are currently saying that accountability between trust boards, ICBs, ICPs and NHSE/I regions feels very opaque and potentially confused. Adding an additional formal layer of place-based accountability for outcomes, without being clear how these accountabilities fit with those of ICBs, trusts or local authorities would blur lines of accountability even further. In particular, it is hard to see how a single leader can be accountable for the delivery of shared outcomes across the NHS and local authorities given existing statutory accountabilities for both systems will remain in place. This will lead to much greater complexity and high levels of risk being carried across all the different players in a system.”

*b) The relationship between Local Authorities and NHS at place level.*

Writing in the Local Government Chronicle (16 February 2022), Andrew Cozens, an independent social care and health specialist, says that the White Paper proposals pivot on bringing together the strategic planning of ICSs with the delivery of services and shared outcomes at place (or council) level.

However,

“There is a fundamental flaw in this approach. It equates the delivery of social care and the role of local government with that of the NHS at place level. Local government has a much wider leadership role at place level covering a range of economic, environmental and infrastructure issues. As far as social care is concerned it has little direct delivery and typically only commissions around half of the social care in any locality. Its leadership of the sector lies in purchasing and shaping in the market rather than directing providers.”[[3]](#footnote-3)

**3.2. Shared outcomes**

In addition to nationally set outcomes, the White Paper proposes shared outcomes are agreed at place level. Work is on-going to develop a framework to provide a set of national priorities and an approach that places can take to prioritise shared outcomes at local level. Initially, outcomes will focus on health services, the public’s health and adult social care. Implementation of shared outcomes is expected to begin from April 2023.

It seems that the ICB (and ICP) will be by-passed in setting these shared outcomes. However, ICSs (does this mean ICBs?) will provide support and challenge to each local area as to the assessment of need and local outcome selection, plus plans to meet both national and local outcomes. CQCs will consider the outcomes agreed at place level in their assessment of ICSs.

**3.3. Finance and integration**

According to the White Paper,

“Local leaders should have the flexibility to deploy resources to meet the health and care needs of their population, as necessary. NHS and local government organisations will be supported and encouraged to do more to align and pool budgets, both to ensure better use of resources to address immediate needs, but also to support long-term investment in population health and wellbeing.”

Pooled budgets will eventually cover much of the funding for health and social care services at place level. “Pooling agreements will remain subject to both NHS and local authority leadership and NHS system and place leaders agreeing what constitutes a fair and appropriate contribution”. To support this, regulations underpinning S75 of the 2006 NHS Act are being reviewing and ‘simplified’. The approach to pooled budgets will also be supported by other measures such as Joint Committees, personal budgets, the Triple Aim duty, and the strengthened duty to cooperate.

NHS Providers are cautious in response, saying that the White Paper’s expectation of

“greater pooling of NHS and social care funding – without altering the underlying financial flows, infrastructure and accountabilities – will introduce further risk into an already fragile, and under-funded, system. This is particularly concerning given the absence of wider reform, and financial support, for social care.”

In the press statement incorporated in their Next Day Briefing, they say: “Pooling NHS and social care budgets is no substitute for funding both systems appropriately and placing social care services on a sustainable footing.”

The Local Government Association also sees an urgent need for financial investment:

“The proposals for strengthening the levers of integration – leadership and accountability, financial frameworks, digital technology and data sharing, and workforce planning and development – are ambitious and will require major investment and support from national partners.”

They add that without adequate resources for adult social care and public health, local authorities will be “limited in their ability to contribute to pooled and aligned budgets.”

**3.4 Workforce**

The White Paper claims that there is already progress in developing the health and social care workforce within the legislative framework for partnership working in the Health and Care Bill and through investment for social care. It claims, for example, to be delivering 50,000 more nurses for the NHS, while the government’s Adult Social Care Reform paper aims to transform the workforce through an investment of £500 million.[[4]](#footnote-4)

**3.4.1 Workforce planning for ‘one workforce’**

The White Paper promotes integration of the workforce by removing barriers to collaborative workforce planning and working. It flags up some of the problems, such as structural and financial barriers (**“**social care providers and local authorities frequently compete with the NHS, or each other, to attract and retain staff”), especially when factoring in that joined-up care, support and treatment may involve public health, community health services, education, housing and homeless provision voluntary services and unpaid carers. In addition adult social care is largely a private sector market while workforce planning is devolved to publicly accountable local authorities.

The White paper promises “We will continue to work closely with local authorities and care providers to monitor workforce pressures, including identifying whether further action may be required.” However, it does not specify what such ‘action’ might include, or how ‘difficult workforce capacity issues’ might be resolved, other than saying that local government and NHSE will gather “intelligence about the experience and aspirations of people who use care and support services” and incorporate this into the development of guidance for ICPs, so all within an ICS are clear on the role they can play in integrated workforce planning and supporting places develop a ‘one workforce’ approach.

**3.4.2 Workforce Integration**

The White Paper says that to deliver shared outcomes and Place-Based Workforce Integration “local leaders will need to consider how the health and care workforce in

the area can be deployed in the most effective way. This should prevent duplication

across health and care, consider the impacts of one sector on the other, and ensure that citizens’ contact with members of both workforces is coherent and coordinated.”

It suggests a difference between responsibilities at the ICS level and at place level: “While national action can foster the conditions for workforce integration, to make this a reality, places must implement integration in a way that meets their needs.” In order to make this happen, “Local leaders will need to think about what workforce integration looks like in their area, the conditions that are needed, the practical steps required, and who needs to be involved in shaping this.” Given that ICBs will have the flexibility to determine governance arrangements in their area – including the ability to create committees and delegate functions to them – it means that local ‘place’-based committees can be created to plan care. Furthermore, “Places must build a culture that supports integrated service delivery, sets a shared vision, develops a common language that truly covers the whole workforce, and engenders a culture of partnership.”

In addition, training and learning together will play a key role in developing an integrated workforce, “with staff from different sectors, and teams within a sector, learning together and gaining an understanding of the roles of others they work with.”

While this sounds positive it is not clear who will provide, organise or fund this joint training and learning, nor to what extent this is all part of a move towards ‘one workforce’, deskilling, and de-professionalisation. Significantly, NHS Providers and the Local Government Association both question the White Paper’s optimistic approach. In particular they point to the crucial factors of staff shortages in both health and social care, and the lack of parity in pay and conditions.

The White Paper talks of strengthening proposals in the Adult Social Care Reform White Paper (December 2021) for a range of measures to invest in social care staff to recruit and retain them. However, the Local Government Association recognises the difficulties of implementing the proposals: “Without meaningful transformation on pay, many of the ideas put forward in the adult social care white paper (such as a Knowledge and Skills Framework to support career structure and progression) will be hard to deliver because people will have no guarantee of increased pay and reward for their increased skills and may continue to use social care as a stepping-stone to the NHS or other opportunities outside of the sector.”

There is talk that funding will be increased but the White Paper gives no figures, only saying “We will provide funding to support local authorities to prepare their local markets for reform, including by moving towards paying providers a fair rate for care that reflects local costs, including workforce, where appropriate.”

**3.4.3 What prevents flexible deployment of health and social care staff?**

The White Paper talks about removing barriers to collaboration (learning from covid) and developing a workforce equipped to work across sectors.

It does not specify what the barriers to people moving across organisational boundaries are, except: “This is, in part, driven by a lack of cross-sector experience built into training; disparities in career progression, with adult social care in particular viewed as lacking opportunities compared to the NHS, and regulatory barriers.”

In other words the aim is to “…encourage movement of staff within and between sectors, to help build knowledge, relationships, and experience of different settings.” (again, one workforce). The White Paper does not address the fact that staff are employed by different employers with different terms and conditions. However, it promises a review of regulatory and statutory requirements that “prevent the flexible deployment of health and social care staff across sectors.”

The Local Government Association welcomes this “interesting and important” proposal: “The LGA has long advocated such changes to ensure public health staff can move between NHS and Local Government without losing aspects of continuity of service and this and other changes will be important for widescale workforce integration.”

**3.4.4 Integrated skills passport – transfer skills and knowledge**

The Local Government Association urges further detailed discussion and consultation with employers on the idea of the skills passport and how it would link to the knowledge and skills framework, but argues that “Without significant action on recruitment, retention, wellbeing and coordinated planning, the ambitions in this white paper will not be able to succeed.”

NHS Providers also welcome the idea of ‘passporting’ but see difficulties: “There is a welcome emphasis on the potential of passporting, but no recognition of – or solutions to address – the practical, legal and contractual challenges that act as barriers to implementation.” In addition, they say

 “One of the challenges will be the disparity in pay levels and conditions of employment between staff from the two sectors. It remains unclear how ICBs and/or place-based partnerships will adopt workforce planning responsibilities when the levers, and information to do so, sits outside of their control (e.g. medical and nursing training places) and in the absence of the data, tools and support to do this.”

**3.4.5 Increasing appropriate clinical interventions that social care staff can do**

The White Paper wants to **“**explore appropriate interventions that can be safely delegated or transferred between the sectors”. It does not give examples of what this might mean. While the Local Government Association sees that “The delegation of further clinical activities to care workerswill have to be supported by training and a transfer of resources”, NHS Providers makes no comment about this apparent de-professionalisation of clinical roles.

**3.4.6 Link workers, care navigators, care coordinators**

The White Paper goes further with reference to particular job roles, referring to plans to remove barriers that prevent particular professions working across settings and make the best use of each person’s skills. This will:

“promote the importance of the roles of link workers, named key worker and care navigator roles [as set out in the HEE’s Care Navigation Competency Framework] as crucial enablers of integrated care provision. Current care navigator roles exist in multidisciplinary teams, or voluntary services, and are responsible for delivering assessments, advice, signposting, and coordination. Care managing in this way offers ways of sensibly sharing work and responsibility, helping to relieve front-line clinician pressures and improve overall quality of care for patients.”

Neither the Local Government Association nor NHS Providers make any specific reference to these roles.

**3.4.7 Volunteering**

It is of concern that the White Paper raises the possibility of health and social care work being done by volunteers. It cites the NHS Volunteer Responders Programme during the pandemic, supporting thousands of people who were shielding, and says, “DHSC and NHSEI have been working together on a scheme to build volunteering capacity for local health and social care systems. This type of joint action can strengthen community ties and improve life outcomes for health and social care users.” It refers to “The creation of ‘blended’ enhanced home care roles that take on elements of some interventions previously carried out by district nurses has been piloted in Tameside (Greater Manchester) with plans to scale up in other Greater Manchester localities.” But it gives no further information on what this has actually involved.

**3.5. Digital**

**3.5.1 Sharing data**

The White Paper claims that joining up data, along with a suite of standards and the development of standard terminology, will be important for improving staff access as well as giving patients access to their own shared care record across health and care services (this is in order to take more control of their health and keep themselves well!).

There are several references to the importance of health and care providers within an ICS reaching a certain level of digital maturity.

Basic shared care records are now in place in almost all ICSs but must cover the entirety of a person’s life for both health and social care, which they currently don’t. “We will also reinforce the use of the NHS number universally across social care”.

Systems will be put in place to link and combine data to enable improved direct care and better analytics for population health management.

“This includes connecting data from every health and social care provider to provide a near real-time picture of NHS care at ICS, regional and nation levels to enable transformation of care pathways and providing insight to all users through *user led product design* (?) and supporting deployment functions.”

**3.5.2 Data governance**

The Health and Care Bill, if passed, will mandate standards on how data is collected and stored so it can pass through the system in a useable way. The Bill also creates a statutory duty for organisations within the health and care system to share anonymous data.

The White Paper refers to a Health and Social Care Information Governance Portal that provides guidance to health and social care workers on information sharing. This includes a Framework for Shared Care Records (possibly at odds with the requirements set out by the Information Commissioner’s Office) to support the workforce in having confidence in sharing information where appropriate.

**3.5.3 Data workforce**

According to the White Paper, guidance from the Health and Social Care Information Governance Portal

“recognises certain roles within the adult social care sector such as registered managers to be ‘health and care professionals’, which ensures that information can be more easily shared across health and social care settings.” (4.14)

Increased access to shared data records implies the involvement of multiple data controllers and processors and, as the White Paper puts it in its final section, the next steps must include “ensur[ing] all professionals have access to a functional single health and adult social care record for each citizen (by 2024)”. However, its definition of ‘professional’ is troublesome. Echoing the aims of the Health and Care Bill to deregulate and blur professional boundaries, the White Paper supports moves to widening access to personal health data by ‘professionalising’ those working in the digital, data and technology industry.

Currently, the Data Protection Act 2018 only permits the processing of special category data (e.g. personal health data) by (or under the responsibility of) a professional who is subject to an obligation of professional secrecy (Article 9 (3). This could be a social worker or health professional (such as a doctor, nurse, dentist or clinical scientist). Processing is also allowed by a person who, in the circumstances, owes a duty of confidentiality under an enactment or rule of law. The White Paper gives no hint of how the new ‘profession/s’ they envisage will be regulated, what code of practice must be followed, who can claim membership, what qualifications are needed, and whether they will owe a duty of confidentiality under law.

Significantly, the White Paper promises ”We will support digital transformation by formally recognising the digital, data and technology profession within the NHS Agenda for Change.”

According to the White Paper,

“NHSX has supported Health Education England to build the next cadre of digital leaders through the NHS Digital Academy. We are addressing the specialist tech skills gap through *professionalising the digital profession*, bringing in talented tech graduates, increasing the number of apprenticeships offered and harnessing talented entrepreneurial and analytical clinicians through the Clinical Entrepreneur scheme and new fellowships” (our emphasis).

It goes on to mention the creation of AnalystX by NHSE and NHSX, described as

“fundamental to the future professionalization agenda for data and analytics and building the necessary capacity and capability within the system to realise the ambitions of the 2021 data strategy.”

 AnalystX is a 16,000-strong, on-line community of practice for ‘data professionals and analysts’ to share knowledge and support “the development of analytical skills for transformation”. It was originally intended as an internal forum for analysts working at NHSE but is now open to analysts with an interest in these fields. Among AnalystX’s core set of values, said to be fundamental to all of its shared activities, is ‘Innovative’ (sic), explained as

“A rich [Strategic Partners](https://future.nhs.uk/DataAnalytics/view?objectId=27093488) programme currently with 34 partners including organisations like AWS, Microsoft, Google, techUK and AphA that support the development of new community content and initiatives.”[[5]](#footnote-5)

We are concerned that widening access to sensitive category data by attributing professional status to employees of the digital, data and technology industries without safeguards or the regulations governing a profession is both unsafe for patients and further embeds the private sector within the NHS.

KONP ICS Working Group

March 2022

**Appendix 1.**

**NHS Providers response**

<https://nhsproviders.org/media/693070/nhs-providers-next-day-briefing-integration-white-paper-final.pdf>

These proposals are complex and may have far-reaching implications that need to be worked through with the sector before being taken forward. Introducing a single person accountable for health and care at place, and expecting greater pooling of NHS and social care funding – without altering the underlying financial flows, infrastructure and accountabilities – will introduce further risk into an already fragile, and under-funded, system.

**Context and timeframe**

Health and care leaders are currently managing unprecedented operational pressures at the same time as significant reform, with the health and care bill currently expected to become law in April 2022. In our engagement with the government ahead of this publication, we asked that these challenges were not exacerbated by the introduction of new, overlapping structures or conflicting, additional policy aims. We are therefore concerned that, by setting national expectations at place level, the white paper risks cutting across the bill and role of ICSs. In addition, the timescales for implementation will be extremely challenging given on-going pandemic disruption, the recovery task, and in the context of the delay to full implementation of statutory ICSs to July. To avoid further disruption, we welcome the white paper’s assurances that there are no national plans to make further changes to ICS boundaries.

**Governance and accountability**

NHS Providers welcome the flexibility given to places to decide which governance models and leadership arrangements to adopt, especially given the differences in population size and geographical differences between OCSs. However, they are very concerned that governance and accountability structures at all levels of system working, including at place, are already being made less clear, under the health and care bill. It is very striking how many trust leaders are currently saying that accountability between trust boards, ICBs, ICPs and NHSE/I regions feels very opaque and potentially confused. Adding an additional formal layer of place-based accountability for outcomes, without being clear how these accountabilities fit with those of ICBs, trusts or local authorities would blur lines of accountability even further. In particular, it is hard to see how a single leader can be accountable for the delivery of shared outcomes across the NHS and local authorities given existing statutory accountabilities for both systems will remain in place. This will lead to much greater complexity and high levels of risk being carried across all the different players in a system.

**Increased pooling of NHS and adult social care budgets**

Pooling budgets can be a good way of aligning decision-making across the NHS and social care, and many ICSs are already considering what budgets it would make sense to delegate to places based on their local contexts. We are pleased that the government “will not at this point mandate how [pooling budgets] is achieved”, which would have undermined the intention to create a flexible national policy and legislative framework for ICSs.

But there is still an expectation that a “significant and, in many cases, growing proportion” of health and care spend will eventually be pooled at place level. We remain concerned that this approach would risk the NHS budget becoming exposed to severe and well-established funding pressures in social care. …..We are also concerned that this proposal overlooks the reality that delegation to places does not make sense in every ICS, as the composition and footprints of local communities, local authorities and NHS organisations differ considerably.

While trust leaders will welcome the commitment to review section 75 arrangements, we are concerned that a focus on the mechanics of how to grow pooled budgets quickly risks detracting from more strategic objectives that would actually drive greater integration on the ground.

**Shared outcomes and oversight**

The paper positions the CQC as having a growing and significant role in considering outcomes agreed at place level, in addition to its new role in assessing ICSs and local authorities’ delivery of their social care duties, and its existing role regulating providers of primary, secondary and social care. We are concerned that new duties relating to place could be duplicative, and could place a significant additional burden on CQC’s capacity. In addition, these new roles, which will involve a very different type of oversight to that currently undertaken by CQC, are untested. It will therefore be essential for the CQC to build confidence among those it regulates in its ability to make judgements on integrated planning and delivery, and this will be particularly challenging given the limited engagement time available. It also raises the question of the oversight roles for DHSC, NHSE/I and the Department for Levelling Up, Housing and Communities given that statutory accountabilities for trusts and local authorities are not changing. We urge the national regulators to consult in detail with the provider sector to ensure the regulatory system is fit for purpose.

**Children and young people’s services**

NHS Providers are disappointed that children’s social care is not within the scope of this paper.

**Workforce**

The paper fails to acknowledge the scale of staff shortages in the NHS and social care sector and the national action needed to tackle these. NHS Providers response flags up the challenge posed by disparity in pay levels and employment conditions between the two sectors. It points out that it remains unclear how ICBs and/or place based partnerships will adopt workforce planning responsibilities when the levers and information to do so sit outside their control (e.g. medical and nursing places). The emphasis on passport is welcomed but there is no recognition of the practical, legal and contractual barriers to implementation – or solutions.

**Digital**

The digital chapter helpfully draws on a range of existing and well-known initiatives. However, there are also some missed opportunities in the digital chapter, which also reads as a more prescriptive approach to rolling out EPR than previous iterations of the policy. We have also questioned the lens of the ICS without significant translation to place level, and the focus on digitising existing models of care rather than digital technologies which may reshape service delivery.

*From their press statement:*

“Local partners across health and social care are making steps to better integrate health and care teams but they will need to be supported with much better national planning and information on workforce needs to make this a reality across the piste [sic].

“And while pooled budgets can help align decision-making across the NHS and social care, here again, we support a flexible approach. Pooling NHS and social care budgets is no substitute for funding both systems appropriately and placing social care services on a sustainable footing.

“We would like to see greater weight given to behavioural, relational and cultural factors in supporting local integration, rather than the current focus on structures and funding mechanisms.”

**Appendix 2**

**Local Government Association response** (selected issues)

<https://www.local.gov.uk/parliament/briefings-and-responses/lga-response-health-and-social-care-integration-joining-care>

The response is largely favourable. It welcomes the focus on prevention, but argues that intent and ambition need to be matched with adequate investment. Councils’ public health grant has been cut by 24 per cent on a real-terms per capita basis since 2015/16.

Proposals for strengthening the levers of integration (e.g. financial frameworks, digital technology and data sharing, workforce planning and development) are seen as ambitious and requiring major investment and support from national partners.

A review of existing legal powers, especially S75 (presumably of the NHS Act 2006) is welcomed.

The focus on place, and expectation of close collaborative working between ICSs and places is seen as a welcome counterbalance to the recent focus on the role of ICSs (presumably meaning ICBs/ICPs?)

It points out that place-based health and well-being boards already have statutory duties to develop joint strategic needs assessments and joint health and well-being strategies.

It argues that in determining place boundaries, ICSs should build on those of councils that have health and well being boards, and that many existing strategies, plans and partnerships are organised on the basis of council boundaries.

The LGA is disappointed, given the focus on the role of housing in the adult social care paper, that there is so little reference to housing as a key component of integrated care.

It strongly welcomes the focus on digital and data, and that the Digital Data and Technology profession will be recognised within Agenda for Change

The LGA welcomes the greater use of pooled and aligned budgets, and the flexibility for place based leaders to deploy these to their own priorities, but the use of these budgets must be seen in the wider financial context for the NHS, adult social care and public health**.**

On delivering integration through workforce and carers, the LGA sees that ambition for the workforce won’t succeed without proper action on pay. The delegation of further clinical duties to care workers will have to be supported by training and transfer of resources. Staff shortages have to be addressed. The proposed regulatory change to ensure more flexible movement around the system is important: the LGA has long advocated such changes to ensure public health staff can move between the NHS and local government without losing continuity of service.

1. <https://www.england.nhs.uk/wp-content/uploads/2021/06/B0660-ics-implementation-guidance-on-thriving-places.pdf?dm_i=21A8,7IYP9,184WW0,UNKBW,1> p6 [↑](#footnote-ref-1)
2. This of course means the involvement of the private sector – to give one example, almost all care providers are private companies*.* [↑](#footnote-ref-2)
3. <https://www.lgcplus.com/politics/lgc-briefing/the-fundamental-flaw-in-health-and-care-integration-white-paper-16-02-2022/> [↑](#footnote-ref-3)
4. The Skills For Care report *‘The State of the Adult Social Care Sector and Workforce in England* 2021’ estimates that the number of people working in adult social care is 1.54 million, so £500 million would provide just £325 each.

A briefing from the Health Foundation, the Kings Fund and the Nuffield Trust ‘*The Value of Investing in Social Care*’, October 2021, quotes the Health Foundation’s REAL Centre projects that the government would need to spend between an extra £2.5bn (just to meet future demand) and £9.3bn (to also improve access to care and pay more for care) by 2024/25. The recent funding announcement covers only some of this, providing around £1.5bn a year. [↑](#footnote-ref-4)
5. <https://digitalhealth.london/the-analystx-story> [↑](#footnote-ref-5)