Browne Jacobson

# Integration and innovation: working together to improve health and social care for all [Part 1] - working together and supporting integration

We set out and consider each legal proposal in the section on working together and supporting integration.

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In the Foreword to the 'Integration and innovation: working together to improve health and social care for all' White Paper it is stated that:

> *"At its heart, however, this Bill is about backing our health and care system and everyone who works in it. Our proposals build on the NHS's own – those in the Long Term Plan. We're also outlining steps to support everyone who works to meet people's health and care needs. Taken together, they will help us build back better after Covid."*

Below, each legal proposal in the section on 'Working together and supporting integration' is set out and considered. The other sections will be considered in separate articles and we will also publish more detailed articles on specific topics. However, overall it is apparent that the proposals do enable the development of an integrated care system on a clear statutory basis, which is not possible under the current legislative framework.

In setting out a brief overview of the proposals for legislation the headings in the White Paper have been adopted.

### Working together and supporting integration

## 1. Establishing Integrated Care Systems

As is apparent, legislative change is now required to enable the development of ICSs into stronger and more streamlined decision-making authorities. The creation of a statutory body and other arrangements will also embed accountability for system performance and delivery ultimately through to the government and Parliament. In making the legislative change, it would appear that flexibility will be maintained, as system arrangements will be set against a small number of consistent requirements which each of the partners who make up that system can then supplement with further arrangements and agreements that suit them.

The government is proposing to establish ICSs as statutory bodies, made up of an ICS NHS Body and an ICS Health and Care Partnership (together referred to as the ICS). This will strengthen the decision-making authority of the system leadership and embed accountability for system performance into the NHS accountability structure. The dual structure is to recognise two forms of integration:

- The integration within the NHS to remove some of the cumbersome barriers to collaboration and to make working together across the NHS an organising principle; and
- The integration between the NHS and others, principally local authorities, to deliver improved outcomes to health and wellbeing for local people.

Obviously, a question which arises with the creation of an ICS Health and Care Partnership is how that will work alongside the current Health and Wellbeing Boards, so as to avoid role duplication in an ICS. The White Paper indicates that the ICS will have to work closely with local HWBs as they have the experience as 'place-based' planners. That will require the ICS NHS Body to have regard to the Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies that are being produced at HWB level. However, there is no suggestion that HWBs will necessarily need to form the structure on which the ICS Health and Care Partnership is based and so it seems this will be left for local determination.

In terms of the intended role of the ICS NHS Body then, its responsibilities will be:

- Developing a plan to meet the health needs of the population within their defined geography;
- Developing a capital plan for the NHS providers within their health geography;
- Securing the provision of health services to meet the needs of the system population.

As anticipated from NHSEI publications, the ICS NHS Body will merge some of the functions currently being fulfilled by non-statutory STPs/ICSs, what we have called the policy functions, with the statutory functions of a CCG. The proposals would also allow for the ICS NHS Body to delegate significantly to place level and to provider collaboratives. Which will mean that ICSs need to think about how they can align their allocation functions with Place, for example through joint committees, though we are leaving this to local determination. NHS Trusts and Foundation Trusts (FTs) will remain separate statutory bodies with their functions and duties broadly as they are in the current legislation.

To support the ambition for ICSs to also address broader health outcomes - including through improving population health and tackling inequalities - each ICS will also be required to establish an ICS Health and Care Partnership, bringing together health, social care, public health (and potentially representatives from the wider public space where appropriate, such as social care providers or housing providers). This body will be responsible for developing a plan that addresses the wider health, public health, and social care needs of the system. A plan which the ICS NHS Body and Local Authorities will have to have regard to when making decisions.

The proposals seek to enhance local bodies working in partnership both within the health and social care system, and more widely. To do this the government will make it easier for organisations to work closely together, for example, through proposals for new joint committees and existing collaborative commissioning arrangements (such as s.75 of the NHS Act 2006). This joint approach to working will also be supported by the “triple aim duty”.

As to financial issues then:

- NHS England to have an explicit power to set a financial allocation or other financial objectives at a system level.
- The ICS NHS Body will have a duty to meet the system financial objectives which require financial balance to be delivered.
- NHS providers, within the ICS, will retain their current organisational financial statutory duties.
- Generally, the ICS NHS Body will not have the power to direct providers, and providers’ relationships with the Care Quality Commission will remain unchanged. However, these arrangements will be supplemented by a new duty to compel providers to have regard to the system financial objectives so both providers and ICS NHS Bodies are mutually invested in achieving financial control at system level.

Overall, the new ICS will enable greater integration between health and social care, reducing the need for most of the governance workarounds currently being used, with each system having the flexibility to create its own arrangements against a small set of consistent requirements.

# 2. Duty to Collaborate

A new duty to promote collaboration across the healthcare, public health and social care system will be introduced. As existing duties emphasise the role of the individual organisation there is a need to rebalance these duties to reflect the need for all health and care organisations to work collaboratively.

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

Therefore, there will be a much clearer duty on NHS organisations and local authorities to work collaboratively, which should also influence the design of the system arrangements.

# 3. Triple Aim

The government proposes to implement NHS England’s recommendation for a shared duty that requires NHS organisations that plan services across a system and nationally, as well as NHS Trusts and FTs to have regard to the ‘Triple Aim’ of better health and wellbeing for everyone, better quality of health services for all individuals, and sustainable use of NHS resources.

In introducing the triple aim as a shared duty that should enhance integrated system working and provide statutory clarity around the common objectives that each statutory NHS organisation must work to achieve.

# 4. Power over Foundation Trusts Capital Spend Limits

NHS England's recommendation for a reserve power to set a capital spending limit on Foundation Trusts, which will support the third aim of the Triple Aim duty, in relation to sustainable use of NHS resources, has been accepted by the government.

This power reflects a move away from each organisation making decisions in its own interests and supports the collaborative approach the new legislation envisages.

# 5. Joint committees

The White Paper proposes creating provisions relating to the formation and governance of joint committees and the decisions that could be appropriately delegated to them. It is intended that:

- ICSs and NHS providers will be able to form joint committees; and
- NHS providers will be able to form their own joint committees.

Both types of joint committees could include representation from other bodies such as primary care networks, GP practices, community health providers, local authorities or the voluntary sector.

The wider ability to create joint committees across the system will create much greater flexibility in decision-making and end some of the work arounds created to enable integrated working.

# 6. Collaborative Commissioning

The proposals will:

- Give NHS England the ability to jointly commission its direct commissioning functions with more than one ICS Board, allowing services to be arranged for combined populations;
- Allow ICSs to enter into collaborative arrangements for the exercise of functions that are delegated to them, enabling a lawful "double-delegation";
- Allow groups of ICSs to use joint and lead commissioner arrangements to make decisions and pool funds across all their functions (and not just commissioning functions);
- Enable a greater range of delegation options for section 7A public health services, including the ability for onward delegation of the function into collaborative arrangements, such as a section 75 partnership arrangement; and
- Enable NHS England to delegate or transfer the commissioning of certain specialised services to ICSs singly or jointly, or for NHS England to jointly commission these services with ICSs if these functions are considered suitable for delegation or joint commissioning subject to certain safeguards. Specialised commissioning policy and service specifications will continue to be led at a national level ensuring patients have equal access to services across the country.

Once again, these proposals will increase flexibility in commissioning and make the mechanisms for collaborative commissioning much clearer than they are in current legislation. It will also make it much easier to develop fully integrated pathways of care, that include public health, specialist services and services currently commissioned by CCGs and to manage such pathways more easily as a result of the simpler governance.

# 7. Joint Appointments

There will be a specific power introduced to issue guidance on joint appointments between NHS Bodies; NHS Bodies and local authorities; and NHS Bodies and Combined Authorities. The intention is to aid the development and delivery of integrated care and ensure that there is a clear set of criteria for organisations to consider when making joint appointments.

Currently, various models have been used to achieve joint appointments, but greater clarity through clear guidance will be welcome to ICSs as they develop.

# 8. Data Sharing

Building on the successful data sharing in response to Covid-19, the government wants to ensure that health and care organisations use data, when they can do so and with appropriate safeguards, for the benefit of individuals and the wider health and social care system.

Whilst the forthcoming Data Strategy for Health and Care will enable greater data sharing, it is apparent that the objectives in it may require primary legislation and proposals include:

- Requiring health and adult social care organisations to share anonymised information that they hold where such sharing would benefit the health and social care system.
- Introducing powers for the Secretary of State for Health and Social Care to require data from all registered adult social care providers about all services they provide, whether funded by local authorities or privately by individuals, and require data from private providers of health care.
- Making changes to NHS Digital's legal framework to introduce a duty on NHS Digital to have regard to the benefit to the health and social care system of sharing data that it holds when exercising its functions; and clarify the purposes for which it can use data.
- Introducing a power for the Secretary of State for Health and Social Care to mandate standards for how data is collected and stored, so that data flows through the system in a usable way, and that when it is accessed/provided (for whatever purpose), it is in a standard form, both readable by, and consistently meaningful to the user/recipient.

The power of successful data sharing legislation and policies is an important pillar to create truly integrated health and social care. Removing inconsistency and uncertainty of approach when it comes to delivering health and social care services is an important ask of the legislative proposals.

# 9. Patient Choice

The government's intention is to repeal section 75 of the Health and Social Care Act 2012 Act (including the Procurement, Patient Choice and Competition Regulations 2013) and replace the powers in primary legislation under which they are made with a new provider selection regime. Under the new model, bodies that arrange NHS Services as the decision-making bodies will be required to protect, promote and facilitate patient choice with respect to services or treatment.

We have published a separate paper on the NHS Provider Selection Regime consultation and will be holding focussed webinars on these proposals.

# Comment

The Working together and supporting integration section of the White Paper makes for very interesting reading and sets out many of the proposals which NHSEI had previously put forward. During our work with developing ICSs, it has become clear that the incongruity between the current legislative framework and the Long Term Plan was a barrier to fully achieving the integration which the government and NHSEI envisaged. These proposals, subject always to seeing the final detail of them, will go a long way to achieving a compatibility of purpose to achieve the integration of health and social care for the benefit of all patients and citizens.

In the coming weeks Browne Jacobson will publish further articles on the White Paper and the NHS Provider Selection Regime. We will also hold webinars to share views on the proposals and how to take forward current work on system design which incorporates the flexibility to move seamlessly into the proposed new legislative framework.

# Contact


Gerard Hanratty

Partner

gerard.hanratty@brownejacobson.com

+44 (0)330 045 2159

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