“Integration and innovation: working together to improve health and social care for all”

The scrutiny perspective on the Government’s health and care White Paper

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This is a paper primarily intended for local government scrutiny practitioners, to set out some of the principal components of the Health and Care White Paper, to highlight particular issues with respect to the health scrutiny function, and to set out how we suggest Government’s proposals be amended.

About Centre for Governance and Scrutiny

CfGS is a social purpose consultancy which social purpose consultancy and national centre of expertise. Our purpose is to help organisations achieve their outcomes through improved governance and scrutiny. CfGS exists to promote better governance and scrutiny, both in policy and in practice. We support local government, the public, corporate and voluntary sectors in ensuring transparency, accountability and greater involvement in their governance processes.

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1. Background to the White Paper

The last major restructure and reorganisation of the NHS in England (in 2013) involved the creation of clinical commissioning groups (CCGs) and a national service commissioning system overseen by NHS England. In respect of local accountability, the main change was the establishment of Local Healthwatch to replace Local Involvement Networks (LINks). In respect of overview and scrutiny functions, the law remained largely unchanged, although new Regulations were laid to consolidate and update existing powers. CfGS produced guidance on the operation of these powers in 2014. Since 2016/17 the NHS in England has been on a path towards increased integration and partnership working – between NHS bodies, and between NHS bodies and others, such as local councils.

This began with the establishment of "sustainability and transformation partnerships" (STPs), and has accelerated with the piloting of "integrated care systems" (ICSs). The development of this agenda has been guided by the NHS Long Term Plan[1].

ICSs are partnerships between a range of organisations that meet health and care needs to co-ordinate, plan and deliver services. ICSs and the integration agenda that they serve is based on a description of health and care activity happening at three levels within a locality[2]:

- System level. Covering a wide geographical area with populations circa 1 million to 3 million, in which the whole area's health and care partners in different sectors come together to set strategic direction and to develop economies of scale;
- Place level. Covering populations circa 250,000 to 500,000 people, and usually coterminous with a local authority area; places are served by a set of health and care provider connecting to services provided by councils, hospitals and voluntary organisations. This is the level at which CCGs currently sit and in the 2013 reforms were the focus of commissioning decision-making;
- Neighbourhood level. Covering populations circa 30,000 to 50,000, served by groups of GP practices (known as "primary care networks" or PCNs) working with community service providers.

The White Paper proposes to place ICSs on a statutory footing and to make a range of structural, and other changes, at place and neighbourhood level.

The White Paper is in part derived from reform ideas developed by and with NHS staff and other health and care professionals; it also draws on institutional learning from the health service's experience dealing with COVID-19.

[1] NHS England and NHS Improvement (2018), "NHS Long Term Plan": https://www.longtermplan.nhs.uk/online-version/overview-and-summary/

[2] NHS England and NHS Improvement (2019), "Designing integrated care systems (ICSs) in England": https://www.england.nhs.uk/wp-content/uploads/2019/06/designing-integrated-care-systems-in-england.pdf

2. Executive summary: main provisions on scrutiny and local accountability

Overall the White Paper envisages a further drawing up of power and accountability for health and care services to the Secretary of State.

Accountability systems at the local level are being reduced, and replaced by broad powers by the Secretary of State to take action and to directly intervene in local services. Significant power and responsibility will now rest at the system level – the level at which statutory integrated care systems (ICSs) will operate.

The White Paper is notable for what is not covered as much as what is. For example, there is little on plans for more meaningful engagement with local people – we expect that the main focus on structures is because of the need to focus on the content of imminent, forthcoming legislation, but it is still a concern. Furthermore, despite the focus on partnership working, it appears to be partnership working on the terms of the NHS as an institution, rather than thinking about how working in partnership will need to involve substantial changes to prevailing organisational cultures in NHS bodies.

The White Paper is best seen as part of a jigsaw which includes the NHS Long Term Plan and the various extant, and forthcoming, pieces of secondary legislation and statutory guidance relating to health and care (including Government's long-awaited plans for social care). It gives us a sense of the whole picture and the rough look of what we can expect when it is complete, but perhaps not enough to make more than a general judgement.

That said, from a structural and cultural perspective, if the White Paper's proposals are translated into legislation without substantial change (and if fundamental new material on engagement, culture and accountability are not, in fact, forthcoming), we are concerned that a reduction in local accountability, and the drawing of increased intervention power into DHSC and the Secretary of State, will make the design and delivery of services more remote and less relevant to local people's needs. This may be exacerbated by the drawing of commissioning up to the system level.

National political accountability is essential for a national health service. If the Secretary of State does consider that these proposals for enhanced intervention should be taken forward, we think that they should be complemented by evidence-gathering and scrutiny arrangements at a local level – this is not a case of either/or. We do not consider that national and local systems of accountability are in tension. We lay out below some areas where we think local accountability, through health scrutiny, can sit in support of national accountability with the Secretary of State.

There are a number of proposals where we have concerns, and/or where we feel a stronger role for local scrutiny should be built in.

<u>Health scrutiny powers in general</u>

The White Paper proposes the creation, as part of the ICS, of two linked bodies whose powers will be found in statute – the ICS "NHS body" and the ICS Health and Care Partnership. Powers around health scrutiny should relate to:

- Both of these bodies;
- NHS trusts;
- Health and Care Partnership bodies insofar as their functions relate to providing services relating to the ICS and its priorities.

This might include:

- Building scrutiny into the "duty to collaborate";
- Requiring the agreement between ICSs and local scrutiny functions on modes of communication and engagement – reflecting the fact that in different areas, to meet different needs, different models of health scrutiny might be necessary. This will also allow councillors to plan to focus their attention on those matters of greatest public contention, adopting a more targeted approach to their work. It will also provide for the ICS to provide support and resources for necessary joint scrutiny, and to facilitate working between ICS scrutiny, place-based health scrutiny, local Healthwatch and place-based scrutiny of HWBs and the delivery of public health priorities;
- Providing for ongoing information sharing with scrutiny, where information is gathered through the work of the ICS.

This framework would support some of the other changes that we describe below. In particular, we consider that a failure by an ICS to meet expectations on these points in relation to a substantial variation could precipitate a referral to the Secretary of State.

The White Paper does not say much about how the ICS will develop its overall priorities and its priorities for commissioning. If the legislation includes the development by the ICS of a statutory plan to reflect the content of the NHS Mandate, we think that there should be an expectation of scrutiny involvement in the delivery of this plan – proportionate, directed, but designed to give both local people and the Secretary of State the assurance that such plans align both with national priorities and local need. Scrutiny can bring support, and constructive challenge, to the development of these plans. We anticipate that the development of these plans would involve wide consultation and public participation and that local scrutiny would provide a mechanism for scrutiny to facilitate this participation.

Scrutiny engagement in specification

The streamlining of the commissioning of clinical services will arguably lead to more focused and responsive services. Commissioning will however need to be informed by high quality specification of services. Where services are being commissioned at the system level for the first time, the need for accurate intelligence on local need is particularly important.

We think that provision needs to be built into primary legislation or Regulations to give scrutiny a formal role in providing support to the way that services being commissioned are specified. This provides a complement to the planning role we describe above, to the generalised place-based scrutiny which we describe in the section below, and the substantial variation powers which we also describe below.

Movement of health scrutiny activity from place level to system level.

Although we know that ICSs will in future be coterminous with local authority boundaries, they will cover wide geographical areas, raising the possibility that councils will be expected to establish joint scrutiny arrangements on a standing basis.

It remains to be seen whether health scrutiny powers will be abolished for all NHS bodies other than ICSs or whether scrutiny of individual trusts, and commissioning focused at the place-level, will still permit authority-specific health scrutiny. We think the presumption remains that place-based scrutiny of NHS services, and services delivered by partners, should continue – supportive of new formal scrutiny arrangements at system level and a new approach to appropriate scrutiny engagement with PCNs.

A continuation of health scrutiny at the place level has benefits, because:

- It benefits from the existing presence of structural arrangements, and resources, to deliver it, as well as from the insight of local elected politicians who are anchored to that "place";
- It reflects the fact that in unitary areas, a considerable amount of planning activity is still to be undertaken at place level – such as the convening of HWBs, the development of JSNAs and the operation of local Healthwatch. In two-tier areas ICSs may map to county areas but may cover a larger geographical footprint;
- It reflects the fact that services are likely to be experienced by local people at neighbourhood and place level, with the system level being relevant for large-scale planning but not for the granular understanding of local services which are a necessary pre-requisite for that planning;
- It means that system-level scrutiny – where necessary – can be managed in a way that is proportionate and relevant to (for example) individual commissioning arrangements rather than the assumption being made that all ICS scrutiny needs to engage with the whole ICS area.

Whatever happens, any system-wide guidance will need to engage with the resourcing and management challenges associated with the joint scrutiny committees which would need to be established to give effect to meaningful scrutiny at the ICS level.

The removal of the power of referral

We note that while it is not proposed that scrutiny's power to review plans for substantial variation is removed, it is proposed to remove its power of referral to

the Secretary of State – a vital longstop which is central to local accountability of health services.

This is framed as a "tidying up" measure to avoid duplication between health scrutiny and the new broader powers being given to the Secretary of State to direct and intervene in reconfigurations. We are dubious whether the granting of enhanced powers directly to the Secretary of State is a sensible response to the challenge of complex reconfigurations but even if it is, we think that health scrutiny can provide vital insight to the Secretary of State on these matters, allowing them to use their powers proportionately.

We think that the referral power should remain, but that it should be cast in the following light:

- A local scrutiny function should be able to refer a matter of local concern on a proposed ICS-led substantial variation at a number of points in the development of such a proposal – for example:
    - Where scrutiny considers that a proposal for change is not in accordance with the NHS Mandate or the ICS's overall plan for the area;
    - Where scrutiny considers that an ICS proposal is not being designed in accordance with the "duty to collaborate";
    - Where scrutiny considers that plans to consult and engage local people are inadequate.

  These reasons are framed to reflect the focus of the White Paper on collaboration and partnership working. Here, scrutiny can act as a local, independent voice to establish whether the ICS HCP is working effectively, and can identify where poor relationships place the delivery of major proposals in jeopardy. We describe this as a "partnership enter and view"[3] responsibility.

- Importantly, we think that these powers of referral should primarily sit at the design stage – far earlier than they currently apply – and that they should be designed to provide "early warning" to the Secretary of State of where emerging problems might exist, in order to ensure that the SoS receives consistent and high quality information, and to ensure that they can use their powers proportionately and in a way that is less likely to be subject to challenge.

The rest of this paper is devoted to a more detailed exploration of some of the components of the White Paper.

[3] "Enter and view" is the legal power held by Healthwatch to direct observe local health services; our suggestion is a strategic complement to this operational power of oversight.

3. Main components

Integration

This is the first of the three main areas of policy focus in the White Paper.

Integration is the name usually given to the creation of joined-up care arrangements across the health and care system. A number of different providers and organisations are responsible for relevant services at a local level – the goal of integration is to ensure that those services are aligned and that they complement each other, and that patients and others have a seamless experience in using them.

Government proposes to integrate services through the legislation in two main ways:

- Integration within the NHS. In part, this will be delivered by putting ICSs on a statutory footing through the creation of both an ICS "NHS body" responsibility for the day-to-day running of ICS services and a wider ICS Health and Care Partnership to facilitate integration. It is unclear from the White Paper whether the Partnership will be a distinct and separate statutory body. There is more than a little of a "strategic health authority[4]" flavour to the way that the White Paper describes the ICS NHS body.
- Greater collaboration between the NHS, local government and other bodies. The NHS and councils will be given a "duty to collaborate" with each other; this will be through the operation of the Health and Care Partnership. It is unclear whether this duty to collaborate will essentially amount to a power for the Partnership, or the ICS NHS body, to "direct" other partners to take action in line with a statutory plan of some kind. The White Paper also promises action on data sharing and "digital transformation", although these are matters where the NHS has a decidedly chequered past[5].

The system will support place-based commissioning but commissioning itself will no longer occur at "place" level. This is being used as an opportunity focus health scrutiny activity at system level, rather than at place level – which we explore in more detail below. This shift upwards of the commissioning powers and the

[4] SHAs were bodies established to provide strategic leadership at a regional level in the NHS, and operated between 2003 and 2013. A useful historical perspective can be found in Edwards N and Buckingham H (2020), "Strategic health authorities and regions: lessons from history" Research report, Nuffield Trust: https://www.nuffieldtrust.org.uk/research/strategic-health-authorities-and-regions-lessons-from-history

[5] The experiences of NHS Connecting for Health (https://en.wikipedia.org/wiki/NHS_Connecting_for_Health) have presumably been learned by those designing new systems.

governance systems which underpin them raise significant questions around patient focus, local insight and local accountability.

Existing arrangements for Health and Wellbeing Boards will continue, and the existing requirements to produce a Joint Strategic Needs Assessment (JSNA), at place level, will continue. However, the context for that work will look very different, and local authorities and other partners operating at this level will presumably have less freedom to act, with commissioning happening at system level. This will have an impact on scrutiny too.

Removal of "transactional bureaucracy"

This is the second of the three main areas of policy focus in the White Paper.

This includes the removal of the oversight role of the Competition and Markets Authority (CMA) over certain aspects of the system. It involves connected changes to the National Tariff, new rules about the creation of new NHS trusts (alongside an assurance that a change to the provider landscape is not being sought), and the removal from statute of local education and training boards (LETBs), whose general functions will continue.

It also involves a wholesale change to the mechanisms by which providers will be chosen to deliver clinical services. Existing arrangements – including section 75 of the Health and Social Care Act, which was particularly controversial at the time of that legislation's enactment – are being repealed.

In its place will sit a new provider selection regime, in which the need for competitive tendering will be removed under certain circumstances, and in which commissioners will be under a duty to act in the best interests of "patients, taxpayers and the local population" when making decisions about arranging healthcare services.

This envisages the significant streamlining of certain procurement and commissioning arrangements, particularly where an existing specialist NHS provider already exists.

Scrutiny, specification and procurement

We have long felt that there is an active role for health scrutiny not in formal involvement in procurement, but in assisting in the specification of new commissioner arrangements. Where commissioners will be under a specific duty to "patients, taxpayers and the local population", elected councillors will have important insight to share on where need may lie, at all levels. We think that statutory guidance associated with this duty should put in place an expectation that for certain clinical commissioning plans, health scrutiny should be consulted.

Accountability and responsiveness

This is the third of the three main areas of policy focus in the White Paper.

NHS England and NHS Improvement are already functionally merged; legislation will formalise this, as well as providing for a merger with Monitor and the NHS Trust Development Authority (which currently form a part of NHSI).

This will bring with it accountability changes for NHS England – in particular, greater powers of intervention by the Secretary of State. The exact scope of these powers of intervention are not set out; there is an expectation that they will apply at national level and that they would not provide the Secretary of State with the power to direct NHS organisations at a local level.

This will be facilitated by a new, rolling NHS Mandate (replacing the annual Mandate process which currently exists). The Mandate is the mechanism by which the Secretary of State sets targets and expectations of the NHS. A rolling mandate will presumably allow ongoing dialogue and negotiation – and possibly informal direction – by the Secretary of State. The White Paper insists that the rolling nature of the Mandate will not impact on existing Parliamentary scrutiny arrangements, but this is moot – the absence of a formal procedure to develop a "new" Mandate will make it more challenging for Parliament to exert oversight at an appropriate time and in a proportionate way.

Scrutiny and the referral power

For scrutineers, the part of the White Paper which will cause most concern is that which relates to reconfiguration intervention.

The local authority referral power for substantial variations in NHS services usually sits with a health overview and scrutiny committee. If councillors consider that consultation has not been adequate, proposals can be referred to the Secretary of State, who may ask that the Independent Reconfiguration Panel consider the issue.

The White Paper proposes the abolition of the IRP and the removal of the power of a local authority to make a referral to the Secretary of State. It proposes the creation of a new, more generalised power for the Secretary of State to intervene, which does not need to be triggered by local action.

The White Paper suggests that the local referral power is being removed to reduce the risk of "duplication" – we do not accept the characterisation that a national power of intervention, and local scrutiny, somehow sit in tension.

The challenge which the White Paper identifies – of referrals coming late in the process – are by and large caused by NHS bodies designing and deploying sub-optimal approaches to engagement both with the public and with local scrutiny arrangements. In a cultural sense, late referral and inadequate consultation of the public at large are closely connected, and speak to deficiencies within NHS bodies at a local level.

The siting of an ongoing power of intervention with the Secretary of State involves the acceptance of a new of arguments, all of which are contentious:

- That the Secretary of State will be able to maintain meaningful oversight of substantial variations being delivered across England;
- That the Secretary of State will be in a position to make a dynamic assessment on:
    - The substantive impact of those changes;
    - The adequacy of consultation and engagement mechanisms being undertaken, as they are being undertaken;
    - The considerations and weighting being given by ICS staff on matters relating to consultation response and design.

The amount of active oversight required by DHSC under these circumstances seems extraordinary, particularly considering that the development of ICSs will by definition involve a substantial shift in commissioning arrangement which will inevitably lead to variations in services.

If the Secretary of State wants to widen their powers to allow for ongoing engagement with substantial variations rather than waiting for the triggering of their powers of intervention by the existing referral power, that suggests a role for local scrutiny to inform that process, and to ensure that the way the Secretary of State uses their powers is proportionate and not subject to challenge. Scrutiny can (and has, in the past) draw together evidence from local people and – because it is led by local elected politicians – have specific credibility and legitimacy in assessing need, both around substantive proposals and the consultation being carried out to support them.

We think that an expansion in local scrutiny powers to provide more generalised oversight on change proposals – a kind of "partnership enter and view" power – would provide a complement to the exercising by the Secretary of State of these powers at a national level, with intelligence and insight being fed up to DHSC to support those Ministerial activities.

Additional powers

There are a number of further powers and changes set out in the White Paper.

Adult social care

The White Paper suggests a range of structural changes which do not address the fundamental challenges raised by professionals and politicians about the ongoing sustainability of social care services. Government has still to publish its proposals for sustainable funding for social paper, despite a Green (and/or White) Paper having been pending for some time.

Where the White Paper does suggest change is in greater oversight for local authorities in carrying out their social care duties, and a new power for the Secretary of State to intervene "in exceptional circumstances" where CQC determines that duties are not being fulfilled. Here we think that some integration of scrutiny's powers in this national oversight would be proportionate.

Other powers

The White Paper makes changes to the Secretary of State's powers on direct payments, discharging arrangements, technical changes to the operation of the Better Care Fund, and the operation of public health at a national level.