

BMA Briefing – Joining up care for people, places, and populations: The government’s proposals for health and care integration

The UK Government has published its latest white paper – [Joining up care for people, places, and populations](#) – which sets out new plans for the integration of health and social care in England.

This briefing provides an overview the white paper and our analysis of its proposals.

The BMA response

The BMA supports the concept of integration and the goal of creating a more collaborative health and care system. However, while aspects of the white paper could support this, it fails to offer the strategic vision or specific policies necessary to deliver the transformation that both sectors need.

Our report [Caring, Supportive, Collaborative](#) and the all-member survey underpinning it clearly illustrated that doctors want to be able to work more effectively across organisational boundaries, for the benefit of their patients and their own working lives.

On this basis, there are elements of the integration white paper that we believe could help deliver improvements for patients, doctors, and health and care services. Agreeing shared outcomes and aligning resources across health and care could, if managed carefully, enable better co-ordination of care, and avoid duplication of effort. Likewise, the focus on locally-led service and workforce planning should mean that both are more closely linked and responsive to local need.

However, there is a critical lack of detail within the white paper as to how its ambitions will actually be delivered. Many of the programmes and proposals set out in the document are framed so broadly that it is difficult to judge how, if, or when they might be implemented. It also repackages and recites long-standing aspirations and announcements which, while welcome when first announced, fail to combine into a convincing or cohesive strategy for integration now.

Central elements of the white paper are also a cause for concern, not least the desire to increasingly pool budgets across health and social care. This is something the BMA has opposed consistently on the basis that NHS funding, which is only now receiving long-overdue increases, should not be used to plug vast gaps in social care budgets.



Fundamentally, though, the principal failing of the white paper is its inability to resolve the deep-seated problems facing the social care sector – funding and workforce. Analysis shows that social care funding needs to increase by £7.5 billion a year by 2024/25 to meet demand, on top of the recent starting point of new Build Back Better support. Meanwhile, the social care workforce receives the lowest wages of almost any sector in the UK, almost [a quarter](#) of the workforce is on zero-hour contracts, and many are only provided with limited sick pay.

Aligning planning, pooling budgets, or championing collaboration across health and care cannot resolve these issues alone. Both health and social care must be properly and independently funded, without this the white paper will fail to secure the change patients and staff need.

The health and care context

The white paper has been presented as the third stage in the UK Government's plans to reform the way that health and social care services in England are planned, delivered, and funded.

It follows the [Health and Care Bill](#), which is currently passing through Parliament and will, if enacted, confirm major structural changes to the NHS, as well as last year's [white paper on the future of social care](#). The BMA is clear that the Health and Care Bill is the wrong Bill at the wrong time and is campaigning for major amendments to be made to it – [visit our webpage](#) for more information.

This new white paper is intended to tie together these existing programmes of work, setting out a broader ambition to better integrate health and social care services and improve the experience of patients and people in care.

This approach reflects a growing recognition of the interdependencies between health and social care services which, while becoming increasingly obvious over recent years, have been thrown into sharp relief by the pandemic. It is increasingly difficult to ignore that problems with capacity, performance, and funding in either service can seriously impact the other.

The white paper aims to resolve this situation by ensuring health and social care services work together more closely at a local level, by more closely connecting the management, planning, and overarching goals of both sectors.

Overview of the white paper

The white paper sets out an array of high level intentions, policies, and plans for how to better integrate health and social care, including:

- designing shared outcomes across health and social care services, focusing on person-centred care, improving population health, and reducing health disparities
- strengthening health and care services at Place level and ensuring they feel familiar to local people - Places will be the 'engines' of delivery and reform
- an expectation for a single person to be accountable for delivering shared outcomes and strong, effective leadership across health and social care at Place level
- illustrating how progress will be made on workforce, digital, and data alignment, alongside pooling finances, as the key enablers of integration and joining-up services
- reinforcing the role of regulatory mechanisms to support integration at place level.

These proposals are targeted at both health and social care services but place the greatest onus on the role of ICSs (Integrated Care Systems) and, in particular, Place.

ICSs are structured into three levels, of which Place is set to play a particularly prominent role:

- 1. System:** where ICS's strategic work will take place, including system-wide management of funding, workforce planning, and service co-ordination. It is made up of two component parts, which will be defined in statute subject to the passage of the Health and Care Bill:

- ICB (Integrated Care Board): responsible for NHS commissioning and funding
 - ICP (Integrated Care Partnership): covering wider issues such as social care and public health
- 2. Place:** based around towns or local authority areas within a system and serving a population of approximately 250,000 – 500,000 people. Work at Place level centres on the planning of localised services and secondary and community care. Place has no statutory basis and its leadership, as well as the intended delegation of powers and resources to this level, will develop gradually and be largely underpinned by guidance – not by the Health and Care Bill
- 3. Neighbourhood:** based around PCNs (Primary Care Networks). Multi-disciplinary teams are central to PCNs, with a focus on health and care professionals working together.

For more information on ICSs and their role within the NHS, [visit our dedicated webpage](#).

Summary and BMA analysis

The proposals within the white paper are broken down into four broad sections:

- shared outcomes
- leadership, accountability, and finance
- digital and data
- the health and care workforce and carers.

This briefing provides an overview and analysis of the Government's plans in each of these areas.

Shared outcomes

The white paper sets out an intention to embed shared outcomes across health and care services, so that providers in both sectors are working towards common goals and that patient treatment and care plans are co-ordinated.

Reducing health disparities

- the Government aims to prioritise prevention, build health resilience, and meet the multiple health and care challenges facing England's population
- integration is seen as central to that aim and to reducing both health inequalities (referred to as disparities in the white paper) and improving population health
- the Health and Social Care Leadership Review will look to strengthen the leadership of health and social care in England, considering how to foster and replicate examples of good leadership and how to reduce regional disparities in efficiency and health outcomes.

Why shared outcomes matter

- systems and local partnerships have increasingly worked collaboratively to deliver shared outcomes, DHSC (Department of Health and Social Care) is looking to amend national frameworks to expand that
- outcomes frameworks will be introduced for public health, the NHS and adult social care, as well as outcomes for local government - incorporating priorities set in the Long Term Plan
- outcome frameworks, prioritisation exercises, and processes designed for one or more organisations will be aligned, to allow integration to develop further and faster
- what counts as a 'good' outcome will also be redefined and will increasingly require closer working with people using health and care services – with the goal of people taking more control over decisions about their care
- DHSC will work with stakeholders to set out national priorities and a broader framework for local outcome prioritisation for implementation from April 2023.

Design principles for a shared outcomes framework

- this element of the white paper focuses on the adoption of locally-agreed shared outcomes across health and social care services – with both sectors working towards a common goal
- DHSC believes that Place is the correct decision-making level for agreeing local outcomes and shaping shared outcome frameworks

- shared outcomes will need to be designed by partners across the local health and care system and with local people, grounded by an understanding of the needs of the population
- DHSC will set a small and focused set of national priorities that all Places will be expected to deliver alongside their own local priorities
- priorities set at national level will have to allow sufficient space for local prioritisation based on the needs of local populations
- outcomes will sit alongside and complement the statutory responsibilities of ICSs and individual organisations, as well as wider regulatory frameworks - to address the problem of organisations being pulled in different directions by competing outcomes and targets
- regulatory and oversight bodies (e.g. CQC) will also consider the setting and delivery of shared outcomes in their work
- DHSC will ensure that national and local outcomes work together coherently so that there is clarity and consistency for local organisations and partnerships, allowing them to compare progress and share learning with others
- the paper also stresses the importance of outcomes over outputs – with an imperative to focus on good outcomes, even though they are more difficult to deliver
- for long-term outcomes DHSC will identify interim metrics that demonstrate how organisations are collectively making progress towards them.

BMA commentary

The BMA has previously called for health systems to [bring clinicians together at a local level to review the backlog of referrals](#), which could become a crucial aspect of the design of shared outcomes. We believe the development of shared outcomes must fully incorporate the views and expertise of local primary, community, and secondary care clinicians. In the longer-term, the redesign of care pathways for some common conditions may provide alternatives to referrals in secondary care and could allow for the delivery of a wider range of care in primary and community settings.

However, it is crucial that the design of shared outcomes considers the resources necessary to deliver a safe and effective service, without simply shifting work or creating workforce pressures. It is positive that the white paper explicitly states that outcomes should sit alongside statutory responsibilities and regulatory frameworks but, as the BMA has highlighted, the pressure caused by regulatory burdens can be substantial. There is also a risk that already significant bureaucratic burdens could be increased by introducing new outcomes frameworks. The BMA has stressed that constant CQC inspection does not produce improvement unless funding, staffing and appropriate resources are also improved, similar risks exist in the introduction of outcomes frameworks.

It is also essential that clinicians have a voice in local decision making, and that doctors are actively involved in the production of local outcomes frameworks. It is also crucial that, when introducing shared outcomes, there are avenues by which local stakeholders can challenge their design. During the pandemic, the GP partnership model in particular has shown how it can support joined-up, integrated services, and this responsiveness and adaptability led to practices effectively moving to a 'digital front door' model virtually overnight, and this is an example of many which demonstrates the importance of clinician involvement in system design and implementation.

As universal access to healthcare improves, health inequalities are reduced. Any measures that are designed to improve universal access to health services are therefore positive. It is essential, however, that improved access is universal, or the risk of further inequality is increased.

The BMA also has concerns about aspects of the language used in the white paper and the UK Government's rhetoric on health inequity more broadly. The word 'inequalities' has been increasingly replaced with the more passive 'disparities'. If the UK Government is serious about confronting and reducing inequality, it must be honest about its socio-economic roots and the devastation it causes.

Leadership, accountability, and finance

The white paper argues that effective integration requires a shared understanding of leadership and accountability at place level, so that all parties are clear about who is responsible for delivering what, with which levers, and what budgets.

Developing effective leadership

- DHSC's [Health and Social Care Leadership Review](#) is currently examining the quality of leadership across health and social care - it will report to the Health Secretary in early 2022
- subject to the recommendations of the review, DHSC will look to develop a national leadership programme, addressing the skills required to deliver effective system transformation and establish local partnerships.

Clear accountability

- the white paper does not prescribe specific systems of accountability for integration - DHSC maintains that the specific areas for action will differ from place to place
- however, by Spring 2023, all Places are expected to adopt an accountability model with a clearly identified individual responsible for delivering outcomes, working to ensure agreement between partners, and providing clarity over decision making
- local health and care leaders will need to set and agree their shared outcomes and will be held accountable for their delivery
- the white paper also proposes the creation of Place 'boards' which would bring together partner organisations to pool resources, make collective decisions, and plan jointly – this would also see funding and decision-making power devolved to the 'board' by the ICB and local authorities
- the operation and formation of Place 'boards' would be achieved through formal governance arrangements – including definitions of membership – and would have a lead agreed by the ICB and local authorities
- DHSC will work with the CQC and others to ensure there is effective regulation and oversight of these new models, and that they achieve their purposes
- a single person in each Place will be accountable for the delivery of this shared plan and outcomes for that Place.

Financial frameworks and incentives

- funding and financial frameworks have often limited the potential for integration – which the white paper hopes to address
- the principal mechanism for this will be the increased alignment of resources and, where appropriate, pooling of NHS (via ICSs) and local authority budgets
- while pooling of budgets between the NHS and local authorities already occurs, including via the BCF (Better Care Fund), DHSC wants to expand it significantly
- aligning resources is framed as an initial step forward in terms of integration, with pooled budgets – which will require formal agreements – likely to follow as ICSs mature
- NHS and local authority leaders will remain responsible for pooled budgets and will be required to ensure all partners make a fair contribution
- the white paper acknowledges that the pooling of budgets is a complex process and that there are limitations which limit more ambitious models of integration
- to address this, DHSC will review legislation covering pooled budgets (e.g. Section 75a of the 2006 Act) and publish revised guidance
- the BCF policy framework for 2023 will be set by DHSC later this year
- building on this, systems are also expected to work towards devolving an expanding range of services and budgets to Place – encompassing most health and care services by 2026
- DHSC will also build on the ongoing and expanded roll-out of personal budgets and personal health budgets across health and social care.

BMA commentary

The BMA has consistently opposed the pooling of budgets between health and social care. This is not a rejection of the concept of aligning resources, or of integration more widely, but rather a reflection of the severe financial disparity between the two sectors and its potential implications.

Alignment of resources can be welcome when done appropriately, but it is no substitute for funding both healthcare and social care sufficiently. Social care is significantly under-resourced and faces an immense funding gap. By updating [Health Foundation](#) analysis and accounting for recent funding announcements, we have estimated that a further £7.5 billion a year in social care funding is needed by 2024/25 to keep up with cost pressures and demand, and to pay social care staff appropriately, on top of the recent starting point of new Build Back Better support.

Our concern is that pooling health and care budgets could see vital NHS funding diverted to plug this gap in the social care budget – to the detriment of health services. This is particularly important for historically underfunded services such as General Practice, which should have its funding protected. Ultimately, NHS funding should never be used to paper over deficiencies in social care resourcing, instead social care should be sufficiently funded by central Government.

The BMA has argued that leadership within the NHS needs to adapt in order to better facilitate collaboration within and between health and care services, as set out in our report [Caring, Supportive, Collaborative](#). Consequently, we will be closely monitoring the Government’s review of health and care leadership and particularly its focus on supporting managers to effectively build local partnerships and deliver integration.

The creation of Place ‘boards’ is broadly in line with NHSE and DHSC’s standing position on the role of Place within ICSs, though the very limited detail in the white paper is the most that has been provided to date on how this might work in practice. The BMA has been clear that independent sector providers of NHS services should be precluded from sitting on ICB boards and key decision-making committees, this would extend to any Place ‘boards’ too which, if created, should be led by the NHS and local authorities. Likewise, it is vital that Place ‘boards’ include leadership roles for clinicians and guarantee membership for primary care, secondary care, and public health doctors.

The proposal to concentrate accountability for shared plans and outcomes on a single individual at Place level raises some concerns too. Place has never been comprehensively defined by NHS England and its exact role within ICSs can and does vary significantly. This means that some Places may not be ready to take on the degree of responsibility ascribed to them. Likewise, as Place is not set to be given statutory footing within the Health and Care Bill, individuals at that level are unlikely to have many, if any, formal levers to use to ensure adherence to the shared goals they are responsible for.

Leadership at Place level – as at System level – is also highly variable and there may not be readily-available individuals with the experience, skill, or willingness to manage this degree of responsibility. The Government and NHS England will need to be clear about what exactly is expected of Places and their leaders, as well as the support they will have to meet those expectations.

Digital and data

Building on NHSX’s data strategy ‘data saves lives’, the white paper outlines proposals to use digital and data as a catalyst for, and core feature of, the integration of health and care.

- utilising data and technology to enable patients to have greater control and autonomy over their data and how they choose to interact with the health system
- full implementation of a digital shared care record in every ICS, sitting across health and care services and enabling all clinicians and carers to see and contribute to a single record
- bringing all health and care providers up to a minimum standard of digital maturity
- establishing a suite of digital standards for adult social care to enable providers to share information within and between health and social care settings
- implementing systems to link and combine data to improve direct care and produce better analytics for population health management
- introduce mandatory reporting of outcomes to enable care improvement
- introduce a statutory duty for organisations within the health and care system to share anonymous data by default
- continue to improve citizen access to data via the NHS app and NHS.uk, enabling them to access records, book appointments, order prescriptions and set preferences for data usage
- professionalise the digital profession in health and care by seeking to attract high-skilled individuals to dedicated clinical informatic roles

- embed population health management capabilities in ICBs and promote usage of said tools at ICS level
- promote an 'ICS first' approach to encourage organisations within an ICS to use the same digital systems to better support data sharing.

BMA commentary

NHS and social care providers have historically struggled to harness modern IT infrastructure in support of the delivery of health and care. In particular, the use of data has not kept pace with other sectors – with its potential to free-up capacity and improve patient experience vastly underutilised.

As the BMA stated in its [response](#) to NHSX's data strategy, the modernisation of the digital and data infrastructure within health and care is long overdue and desperately needed. While progress towards this has been made in some areas (remote working, the expansion of summary care records and the processing of data for research and planning during the pandemic), there remain significant challenges around how similar progress can be made in others.

Better and more comprehensive data sharing would benefit patients, but key questions around the technical and information-governance barriers remain largely unanswered.

The power to mandate standards is welcome, but without greater enforcement on suppliers to build software to these standards, NHS organisations will be left to carry out unnecessary due diligence on whether software meets standards before procuring. Similarly, the aspiration to upskill the workforce to fully harness the potential of new digital technologies is critical to ensuring their success, but amidst a workforce crisis – it is difficult to see how adequate time can be set aside to do this.

The promotion of an 'ICS first' approach that would compel providers within a system to adopt the same digital systems sidesteps the issue of interoperability. Rather than focusing on the development of interoperable systems as the default model in ICS-led procurement, this model takes a blunt approach in forcing all providers to adopt the same, likely dominant system in place across an ICS. This is particularly disappointing given that the historic development of un-interoperable systems took shape with exactly this outcome in mind – the creation of monopoly, enabling software suppliers to force providers into choosing their system precisely because it has such wide uptake elsewhere.

The health and care workforce and carers

Joined-up services cannot be delivered effectively without a supported, valued, and collaborative health and care workforce. The white paper aims to facilitate workforce integration by removing current barriers to collaborative planning, working, and delivering care, focusing on four main areas.

Improving workforce planning

- in July 2021, DHSC commissioned Health Education England (HEE) to review long-term strategic trends for the workforce, which will now also include regulated adult social care professions. This will take a 15-year forward view in order to guide planning, education, and training for the workforce
- the Health and Care Bill includes a requirement for the Health Secretary to submit a report every Parliament setting out the roles and responsibilities of each of the bodies (at national, regional, and local level) in the system responsible for workforce planning in England
- this is intended to increase accountability and transparency, while providing assurance that the system is making this issue a priority
- DHSC will continue to work closely with local authorities and care providers to monitor workforce pressures in social care, including identifying if further action is required
- DHSC will also work with local government and NHS England to strengthen guidance for systems and increase co-production with social care stakeholders. This will be incorporated into development of guidance for ICPs, to ensure all components of an ICS are clear on the role they play in integrated workforce planning
- the expansion of local feedback for a will be encouraged, building on good practice in a number of regions that have led to closer collaboration.

Learning and development

- in recognition of the value learning and development opportunities bring to cross-team cohesion and partnership working, DHSC will identify ways to improve training offers for staff at the interface between health and social care and promote opportunities for continuous professional development across sectors
- a move towards a more collective approach to promoting careers within health and care as one integrated system with equal value will be reinforced.

Progression and movement between sectors

- to make it easier for the workforce to move between health and social care, DHSC will build on the approach developed within primary care in which roles are increasingly recruited through rotational and joint employment models
- barriers that prevent particular professionals working across settings will be removed, including by promoting the importance of link workers, named key workers and care navigator roles that support people working at the interface between health and social care
- work will be done to ensure consistency across the country in access to these types of roles
- DHSC will consider developing a national delegation framework of appropriate clinical interventions, to increase the range of appropriate clinical interventions undertaken in care settings
- establishing a foundation for the future registration of social care staff in a way that benefits staff and care providers alike
- create opportunities for staff working in certain sectors, for example social housing support and homelessness, to move into roles in adult social care, public health, and healthcare roles
- make best use of the skills of pharmacy professionals by consulting on regulatory barriers, improving placement opportunities, and delivering the Pharmacy Integration Programme.

Place-based workforce integration

- the paper recognises that while ICSs should be a lynchpin between national organisations and Places, it is local leaders who are best placed to efficiently deploy the health and care workforce in their areas, which will differ from Place to Place.
- better supporting local leaders to do this will prevent duplication and ensure a coordinated workforce across both health and social care
- changes in the Health and Care Bill will embed and speed up integration locally, with flexibility for areas to determine which models of integration will work best at Place level
- ICBs will have the flexibility to determine governance arrangements in their area – including the ability to create committees and delegate functions to them - this would allow systems to create local Place-based committees to plan care where appropriate.

BMA commentary

The BMA supports the workforce commitments outlined in the white paper, including HEE's review of long-term strategic trends in the workforce (to which the BMA submitted evidence in September 2021). However, we do not believe this review alone will go far enough in improving either workforce planning or public accountability for it.

The BMA has long-called for a comprehensive national workforce strategy underpinned by long-term, multi-year, and publicly available modelling that takes into account demographic trends, local population need, and health inequalities. We understand that the Health Secretary has recently commissioned NHSE to produce a long-term workforce plan, however, no formal details regarding its timescales, scope, or terms of reference have been made available to date. Any strategy can only hope to be successful, however, if the legislative mechanisms needed to underpin it are in place.

The BMA is one of 90+ health and care organisations supporting an amendment to the Health and Care Bill to strengthen workforce planning. This amendment would place a duty on the Government to publish independent assessments of current and future workforce numbers every two years, in line with OBR (Office of Budget Responsibility) projections. These assessments would inform strategic and long-term decisions about the funding, workforce planning, regional shortages, and skill mix needed to match patient demand. They would also support the health and social care integration agenda by providing a clear baseline against which national and local bodies could make decisions.

Our [Rest, Recover, Restore](#) report recognises the value of training opportunities both for individuals and the collective workforce, and the BMA supports the ambitions set out in the white paper to increase the learning and development offer to staff. This is particularly laudable in social care, in which the disparity in learning and development opportunities in comparison to the NHS is notable. However, for this to work effectively and not add pressure for staff – many of whom will be working under intense stress and covering staff shortages – dedicated time must be carved out for them to engage in these opportunities. Staff who take training opportunities must also not be penalised or expected to make up time elsewhere.

The white paper also does little to address issues facing the social care workforce. While the plans set out to improve training and movement between sectors are welcome, these plans do not go far enough in improving working conditions for social care workers. To achieve effective integration, social care and NHS staff must have parity of esteem.

Currently, the social care workforce receives the lowest wages of almost any sector in the UK. Almost [a quarter](#) of the workforce is on zero-hour contracts and many social care workers are provided with limited sick pay. To remedy this, we believe the Government must set out a long-term funding plan for the social care workforce, ensure that all social care workers are paid the Real Living Wage as a minimum, and develop a standard contract for the social care workforce.

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