



TLAP response to White Paper Integration and Innovation: working together to improve health and social care for all

We have looked at the proposals for improving health and care set out in the White Paper and set out below is our feedback. Our views are largely confined to those aspects which relate most to our interest in personalised and community-based forms of support. It builds on our earlier response to NHS England's consultation on *Next Steps to Building Strong and Effective Integrated Care Systems (ICSs)* across England. This response has been agreed with members of the TLAP Board. We know that some TLAP Partners have already responded in their own right.

TLAP's supports the ambition of improving health and care so that people experience personalised support in line with the [Making it Real](#) statement that *"I have care and support that is coordinated and everyone works well together and with me"*. Removing barriers to integration, getting rid of unnecessary bureaucracy and improving accountability and responsiveness are all worthwhile aims. Set out below are some areas which we think should be considered if the ambition and aims of the White Paper are to be realised.

Improving people's health and wellbeing as the driving force

The legislation and subsequent guidance should more loudly affirm the goal of improving people's health and wellbeing as the driving force of the proposed changes. Such a strong statement is important we think to guard against a risk of a disproportionate focus on structure when it comes to implementing the reforms. It will act as an important point of reference to help remind us all of the central purpose.

Missing links for integration

The White Paper makes it clear that it is not the place for setting out details of the reforms to public health or adult social care. Both are vital to achieving the vision of truly integrated health and care. Without clarity about the role, resources and contribution of public health and social care there is a risk of an unduly narrow view of integration being embedded, even if that is not the intention.

Personalisation needs continued attention

The promise in the Care Act of personalised care and support with choice and control has only been partly achieved. The NHS Model of Comprehensive Universal Personalised Care is still relatively early on in its implementation. It is important therefore that the ICSs have personalisation high on their 'to do list', which should be emphasised in the guidance.

There should also be continued focus at the national level on driving forward with personalisation linked to the transformation and reform of adult social care.

The drive to reduce bureaucracy should extend to reducing the amount of bureaucracy people face when choosing to self-direct their own support through a personal budget or personal health budget.

Co-production as a guiding principle

With the above in mind, we think it imperative that the legislation acknowledges and guidance reinforces the involvement of people with lived experience (including unpaid carers) as a critical success factor in making the proposed arrangements and structures work. The views and experiences of people must be at the heart of these changes and unless this is achieved in a meaningful and sustainable way no amount of structural change is likely to succeed in achieving the objectives of better and more joined up health and care. Involving people must become 'the way we do things around here'.

We endorse the view that it is best not to prescribe the precise working arrangements of the ICS Boards and Health and Care Partnerships in either the legislation or guidance, as they need to fit with local circumstances and be flexible enough to adapt over time. However, we do think that there should be a strong expectation and clear requirement that co-production is woven into their fabric. It cannot therefore simply be a case of 'lifting and shifting' existing patient and public involvement functions from Clinical Commissioning Groups and relying on local Healthwatch, as good as they may be. The bar should be set much higher than this.

This will mean investing in infrastructure (both in cash and kind) to cover the full span (within and across the different levels and layers) from the very local to the big footprint of the ICS, building on existing arrangements that are already proven to work. There is a vital and enhanced role for User Led Organisations and the voluntary, community, social enterprise sector in enabling the voice of the people they work with and for to be heard. This should link with the development, testing and spread of both established and innovative ways of engaging and involving citizens. To ensure that citizen representatives are able to participate as equals conscious thought will need to be paid to 'induction' and ongoing support. If we want to encourage and engage participation from currently under-represented groups and communities, then this support will matter.

Behaviours that make for good change

As the White Paper makes clear the pandemic triggered in many places a collective and collaborative response in a common cause. We need to retain and build on this. Whilst it is not possible to mandate or prescribe collaborative relationships or behaviours, when framing the legislation and guidance, care should be taken to maximise incentives and levers that encourage 'good behaviour' and avoid creating perverse incentives.

A wide definition of wide

We understand the use made in the White Paper of the shorthand term ‘wider delivery partners’. However, the guidance should make it clear that the term should be broadly defined and applied in practice, to include the rich mix of resources and assets in a place, rather than a narrow view limited to contracted organisations of care and health. This will help create the space and environment for innovative asset-based approaches for improving health and wellbeing to take firmer hold and flourish. Rules and behaviours around collaboration and competition will therefore need to be sensitively applied. The direction of travel should be towards citizen led collaborative approaches to commissioning that enables personalised support and builds community connection. On a particular point, the important role played by housing in terms of people’s health and wellbeing should be afforded high status.

Assurance with citizen’s at the centre

We see the case for strengthening accountability for the provision of high quality adult social care in line with the Care Act, but are wary of developing oversight of local authorities if this moves too far ahead of the overdue reform of social care. Much of the accountability should be to people who access social care and unpaid family carers. The assurance framework should be designed with citizens at the centre and co-produced. As a national partnership that brings together system leaders, commissioners, providers and people with lived experience, TLAP is in a good position to help with this.

Human indicators that count

We support improving the data that is available to be used to build a picture of the progress made to improving health and wellbeing. Care should be taken to avoid a disproportionate focus on finance and activity and the risk of creating data sets and flows that have the effect of reinforcing existing patterns of provision, when we know that so much of what is needed is transformation. Any minimum data set should contain measures that tell us about the experience, outcomes and impact on people. We think that *Making it Real* can play a valuable role in this regard, especially as it is designed to run across health and social care.

Discharge to assess

We support the aim of removing the current requirement that assessments should always take place prior to hospital discharge as this is clearly against established best practice. In making any legal changes in support of this, it will be important to ensure there is appropriate cross-referencing to the relevant parts of the Care Act and, importantly, it should be made clear that NHS responsibilities for playing its part in ensuring safe and person-centred discharge processes are not diminished in anyway.

It is essential that all the components for safe and effective discharges are in place (e.g. assessment, rehabilitation, community health, together with specialist health input where this is required) and that social care is properly resourced to support the discharge to assess approach, especially given that we can expect a greater need for social care support as a

result of long Covid. Workforce availability across the board will be key to successful implementation.

Conclusion

TLAP has a breadth and depth of knowledge and insight that comes from having over 50 partners and ten years of experience of working in co-productive ways across the care and support sector. We have particular expertise in co-production, personalised commissioning, self-directed support, and asset-based approaches. We look forward to working with the DHSC and others partners in order that the ambitions laid out in the White Paper can be achieved with the central purpose of improving the health and wellbeing of the population and reducing inequalities.