MEAM:
Policy into practice series

*The **Policy into Practice** briefing series from **Making Every Adult Matter (MEAM)** explores key national policy developments, what these mean for local people and local services, and how you can get involved in shaping what happens next.*

Health reform and its impact on people experiencing multiple disadvantage

September 2021

In February 2021, the Department of Health and Social Care (DHSC) set out its proposal for a new Health and Care Bill including changes to public health and social care. In March 2021, it published further plans for structural reforms to the public health system in England. The new Health and Care Bill is currently making its way through Parliament.

This policy into practice briefing sets out how these upcoming health reforms in England might impact people facing multiple disadvantage, examining central health function reforms, changes to the local structure of health bodies and how services will be commissioned. In particular it covers:

- The current public health function arrangements;
- The new structure of public health in central government;
- Local reforms and integration;
- Reducing bureaucratic processes in commissioning; and
- The likely impact on people experiencing multiple disadvantage.

We recently published an explainer on Integrated Care Systems (ICSs) and how they will function. We recommend reading these documents together.

What are the current public health function arrangements?

Effective health services can support people to access the help they need, when they need it. However, too often services have failed to recognise the wider determinants of health and that silo-ed approaches rarely work for people experiencing multiple disadvantage.

Public Health England is an executive agency introduced under the Health and Social Care Act 2012 to bring together a range of health functions that had previously been delivered through separate government organisations. The functions of PHE include reducing health inequalities, providing funding to local authorities for public health services including substance misuse treatment, advising government and supporting local government and the NHS to plan and provide health and social care services.

Under the Health and Social Care Act 2012, Local Authorities were made responsible for improving the health of their local population and for commissioning public health services including mental health and drug and alcohol treatment. Local Authority hosted Health and Wellbeing Boards were tasked with bringing together NHS, public health, adult social care and children's services.

Currently, Public Health England engages with local areas through regional public health teams, headed up by Regional Directors of Public Health (RDPH). Each region includes local public health centres that provide expert public health advice and support to the local NHS, local authorities and other partners. Every local authority with public health responsibilities must employ a specialist Director of Public Health (DPH).

This year, the Department of Health and Social Care announced that from autumn 2021, the government's health improvement functions will transition from Public Health England (PHE) to a new Office for Health Promotion situated in the Department of Health and Social Care.

The new structure of public health in central government

The DHSC white paper sets out structural reforms to the public health system in England and provides some information about how the future health improvement functions will work.

From October 2021 Public Health England's health protection functions will move to the newly established UK Health Security Agency (UKHSA), with health improvement functions being housed in the new Office for Health Promotion (OHP). The OHP will be a multi-disciplinary unit that will oversee policy development, provide expert advice and implementation on prevention of ill-health, and house delivery projects. Crucially, the government does not propose making any changes to the scope of responsibilities of local authority public health commissioning.

The final design of the new public health structures are still in development, and it is expected that a description of how the new public health services and functions will be organised will be developed this summer, with ongoing design work to develop the Office for Health Promotion and wider changes within DHSC ongoing until autumn 2021.

The OHP will help inform a new cross-government agenda to track wider determinants of health and implement policies in other departments where appropriate, with professional leadership of the office provided by the Chief Medical Officer. The white paper outlines that **'Health will no longer only be the business of the DHSC, but a core priority for the whole of government'.** This will be supported by a cross-government ministerial board on prevention and health improvement. In addition, the secretary of state for health will remain responsible for overall policy decisions and direction, and will be given new powers through the Health and Social Care Bill to intervene in NHS decision making.

As part of the government's wider drugs policy agenda, the government has also announced that it will launch a new cross-government unit on drugs headed by Kit Malthouse MP, Minister for Crime and Policing. The unit will be housed in the Home Office, and – as recommended by Dame Carol Black's review of drugs – will bring

together six key departments working on health, treatment and recovery, employment, housing and the criminal justice system, including support from specialists based in the Office for Health Promotion.

Local reforms and integration

The government want to further embed prevention and health improvement into the NHS at a local level. This will be achieved through the further development of Integrated Care Systems (ICSs), a new statutory aim for the NHS to improve health and wellbeing, and an imperative for stronger joint working between the NHS and local authorities.

We recently published an explainer on ICSs and how they will function. The first ICSs were formed in 2018 and until recently they have evolved with minimal national guidance, resulting in significant differences in their size, maturity, complexity, leadership and governance. However, NHS England has now published the 'ICS Design Framework' and interim guidance which provide further detail about the structure and governance of ICSs, and set out how NHS leaders and organisations will be expected to operate with their partners in ICSs. These will not made formally until the Health and Care Bill has been enacted, but suggest that each ICS will comprise an:

1) **Integrated Care Board (ICB)** that will oversee NHS functions across the whole system. The ICB will as a minimum, include a chair, the CEO and representatives from NHS providers, general practice and at least one local authority partner. The ICB will take on functions that are currently performed by Clinical Commissioning Groups (CCGs), which will be abolished. These include developing plans to meet healthcare need of the population, allocating resources across the system, establishing joint working arrangements with partners and arranging for the provision of health services.

2) **Integrated Care Partnership (ICP),** a joint committee which brings together the ICB and their partner local authorities, and other locally determined representatives such as health, social care and housing providers. The ICP will have a specific responsibility to develop an 'integrated care strategy',

addressing health inequalities and the wider determinants which drive these inequalities and being a forum to support partnership working. The ICB and local authorities will have to have regard to ICP strategies when making decisions. Formal guidance on ICS Partnerships will be developed by the Department of Health and Social Care (DHSC), NHS England and NHS Improvement, and the Local Government Association (LGA), and consulted on ahead of implementation.

Some elements within the framework and guidance have the capacity to help create better support for people experiencing multiple disadvantage. In particular:

- The framework emphasises the importance of place-based partnerships and asks each ICS to define how it will develop place-based partnerships and the agencies involved. It suggests partners should include at a minimum Primary Care Networks, NHS providers, Local Authorities, Directors of Public Health and 'other place representatives'.
- Beyond the board, ICBs will have the flexibility to create committees in their area and delegate functions to them. This would allow systems to create local 'place'-based committees to plan for specific issues where appropriate.
- The framework formalises the encouragement of voluntary organisations in ICS partnerships, and sets an expectation that by April 2022, all ICSs will develop formal agreements for engaging and embedding the voluntary sector in system level governance and decision-making arrangements.
- NHS England will continue to allocate funding based on population need, but the ICS body will agree priorities and distribution between places and providers.
- Partnerships are encouraged to develop a 'one workforce' approach with shared principles and ambitions across all partners such as local authorities.

Reducing bureaucratic processes in commissioning

The framework also re-iterates recommendations, first set out via consultation earlier this year, that government should replace current rules for procuring NHS healthcare services with a set of more flexible arrangements.

Currently, NHS and Public Health service providers are selected through competitive procurement, including mental health and drug treatment services. There are both positive and negative implications to this system for services supporting people facing multiple disadvantage. At its worst however, competitive procurement can be overly bureaucratic, resource intensive and can lead to a 'churn in the system' causing instability and disruption of local systems.

For commissioners seeking to procure health-related services, the new proposals suggest replacing competitive procurement with three options that decision-making bodies could consider when procuring services. These are:

- Continuing existing contracts with the existing provider with no re-procurement or competitive process;
- Awarding a contract directly to a new suitable provider when a service is new or changing substantially, but a competitive procurement is not appropriate; and
- Selecting a new provider by running a competitive procurement.

These proposals would apply to bodies responsible for arranging healthcare services for the purposes of the health service (NHS and Public Health) – including ICS boards and local authorities where they are commissioning healthcare services as part of their public health functions.

Health reforms: How will these affect people experiencing multiple disadvantage and the services supporting them?

Working in partnership and taking a whole systems approach to complex issues, including health, is a key part of the MEAM Approach. The new health reforms have a clear emphasis on taking a whole systems approach to improving the integration of local services supporting vulnerable people, and a clear recognition of the wider determinants of health. We are pleased that the government has signalled its commitment to drive this through a cross-government ministerial board on health prevention. Effective, cross-government collaboration is crucial in driving systems change, and ensuring people experiencing multiple disadvantage get the support they

need. Every government department working to support people facing multiple disadvantage has a role to play in helping to implement the health reforms in the White Paper.

Opportunities

There is currently little detail on the design and implementation of the new Office for Health Promotion. The final design of the new public health structures are still in development in central government, and so current proposals will not directly impact services supporting people experiencing multiple disadvantage. It is expected that a description of how the new public health services and functions will be organised will be developed this summer.

The new OHP will play a vital role in strengthening local accountability, including monitoring local performance regarding drug treatment and holding the system to account, working with the Local Government Association to provide support to local authorities and strengthening the role of Regional Directors of Public health. The government is also considering whether local authorities and Directors of Public Health would benefit from any additional powers, responsibilities or levers, to help them drive change in their areas. It is hoped that that this will create more opportunities to leverage the vital role of partners across the system involved in supporting people experiencing multiple disadvantage.

Local reforms have the potential to drive the agenda of whole-systems approaches and reduce some of the fragmentation and gaps in service that vulnerable people face. For place-based partnerships such as those found in MEAM Approach areas, it is hoped that the new ICS models will be simple to engage with, with clear governance and mechanisms for including place-leaders. In some areas, existing commitments to work on multiple disadvantage through structures such as Integrated Care Partnerships have provided the profile and momentum to attract the attention of ICSs, which has the potential to drive this agenda across a wider footprint.

The move away from using competition as a tool for improvement, putting an end to competitive market-style procurement of services and replacing this with

collaborative, bespoke health services is welcome. There has been some consensus that use of competitive tendering can be inappropriate, burdensome and favours the same services being re-commissioned, pushing out community-led, expert and local responses in the process. The new arrangements will hopefully give commissioners and local systems greater flexibility in how they arrange services, providing opportunities to continue existing arrangements where services are being delivered well, or conversely to pursue new arrangements as needs change.

Challenges

Across the MEAM Approach and Fulfilling Lives networks, the majority of work focussed on multiple disadvantage is conducted at local authority level, with the involvement of local authority public health, housing, social care and voluntary organisation services and representing relatively small cohorts. Conversely, ICSs span across much larger geographic footprints that include multiple local authorities, bigger population sizes, a larger number of voluntary organisations and varied financial and political circumstances. There is a risk that difference in scale will result in ICSs prioritizing wider population health at the expense of outcomes for smaller groups of those facing some of the largest inequalities.

Furthermore, there is a risk that removing competitive procurement requirements alongside the NHS integration agenda could affect the local partnerships and support offers. It is possible that the progression of ICSs and the focus on integration could lead to areas integrating health-based services currently provided by voluntary and community services, such as substance misuse treatment, into mainstream NHS services. The ability to do so without competitive procurement may impact the number of opportunities for local providers to bid for contracts, potentially pushing out specialized community organisations in the process.

In addition, whilst the procurement of health services is key, so are the services that support wider social determinants that underpin good health. There is still further detail needed on the scope of services these new rules will apply to, and it should also be noted that these reforms will not apply to wider local authority commissioned

services such as housing and homelessness, which have equally important roles to play in improving people's health.

Whilst NHS England will continue to allocate funding based on population need, decisions about how much money is spent on types of healthcare and what services are funded will be made by integrated care boards, which will govern Integrated Care Systems. It is crucial that the allocation of funding takes into account local priorities and shrinking local authority budgets, as this is where the majority of work focussed on multiple disadvantage is conducted.

Finally, given the strong focus of the OHP on the wider determinants of health, much of its impact will rest on how effectively the office will work across government to secure sufficient funding in the upcoming spending review.

Conclusion

There are a number of health reforms on the horizon, which are moving at varying speeds and in a constant state of development. There is still a significant amount of information to come, and there will inevitably be further changes that arise as we transition to a new statutory context and from one government department to the next. MEAM and its members will continue to monitor the developments and help to inform services, local practitioners and the people they support of the changes and the impacts on them.

In the meantime, local MEAM Approach areas should be thinking of how best to work with Integrated Care Systems and Directors of Public Health, engaging them in local partnerships, ensuring they are aware of the specific needs of people facing multiple disadvantage and exploring how collaborative work between health and other local services can ensure better support for individuals.

Glossary of terms:

Integrated Care System (ICS) - New partnerships between the organisations that meet health and care needs across an area, to coordinate services that improve population health and reduces inequalities.

Integrated Care Board (ICB) – structures bringing the NHS together locally to improve population health and care.

Integrated Care Partnership (ICP) - the broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS.

Primary Care Network (PCN) - Groups of GP practices working together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas to provide coordinated and more integrated health and social care for people close to home.

Office for Health Promotion (OHP) - a new government office that will sit within the Department of Health and Social Care (DHSC), and will lead work across government to promote good health and prevent illness which shortens lives and costs the NHS billions every year, building on the work of Public Health England.

UK Health Security Agency (**UKHSA**) - a new executive agency responsible for preparing, preventing and responding to threats to the nation's health, including future pandemics.

Director of Public Health (DPH) – Directors responsible for determining the overall vision and objectives for public health in a local area or in a defined area of public health, usually at a local authority level.

Regional Directors of Public Health (RDPH) – Directors responsible for providing oversight and leadership for all public health activities in a particular region, supporting Directors of Public Health and local public health systems.

Further resources

Key Documents for Integrated Care Systems

Information about Integrated Care in Your Area

Resources for integrated care, including webinars and case studies.

Guidance on integrated care systems