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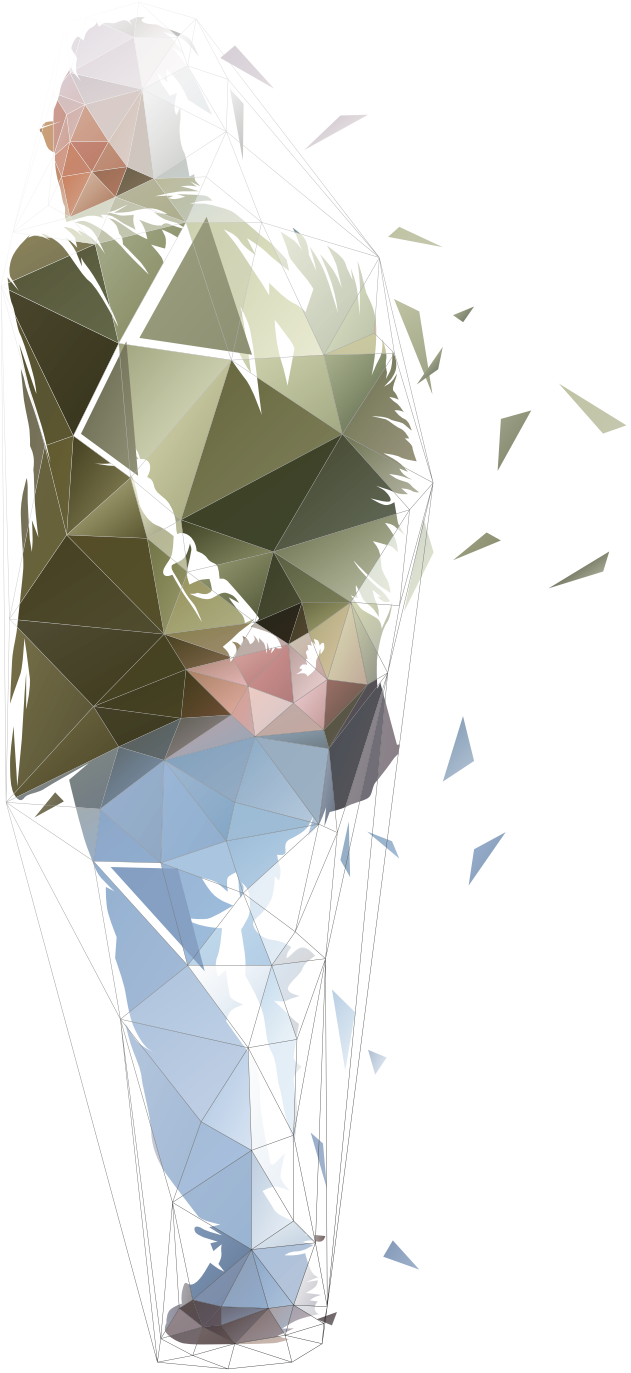
REFLECTIONS ON THE OPPORTUNITIES OFFERED BY THE GOVERNMENT WHITE PAPER ON HEALTH AND SOCIAL CARE REFORM

May 2021



Contents

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Foreword

Trowers & Hamlins recently held a roundtable attended by representatives of NHS bodies, private and voluntary care providers and key sector trade bodies, along with members of Trowers & Hamlin's specialist health and social care team, to consider the opportunities, and also the omissions and possible risks, posed by the Government's recently published White Paper on health and social care reform.

It is clearly stated that the White Paper is based on "asks" from the NHS itself, in particular NHS England to assist in delivery of the Long Term Plan.

Attendees had a wide range of relevant expertise, including clinicians, hospital management and those involved in specialist care and support sectors such as the elderly and those with mental health issues. There has been much focus on the legal changes such as the proposed new ICS legal bodies, with accompanying partnership boards with wider membership. This was an opportunity to get to grips with what they may really mean in practice.

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Attendees

Michael Voges	Executive Director, ARCO
Rhidian Hughes	Chief Executive, Voluntary Organisations Disability Group
Malcolm McFrederick	St Pancras Transformation Programme Director, Camden & Islington NHS Foundation Trust
Diane French	Chief Executive Officer, Reside Housing
Guj Pahal	Lead Clinician for Plastic Surgery, The Surgical Consortium
Carrie Pilgrim	Clinical Assurance Manager, Octopus Healthcare PV Fund
Deborah Bailey	Commercial Director, Cornerstone Healthcare Group Ltd

Key takeaways

1. The health and social care sector need to hang on to the efficiencies developed in part as a response to the Covid pandemic. Whilst there is a need for face to face contact, there have been some valuable learnings about how to manage things using a balance of technology and face-to-face activity. A good example is digital triage followed by one appointment for confirmation of diagnosis and same day local anaesthetic surgery, supported again by digital follow up and home care. This is efficient, effective and necessary if the NHS is to make an impact on the current overlong waiting lists. Even the very elderly are now digitally enabled or can be supported in this. Similarly, support for younger trauma patients can be arranged and is very effective.

2. Investment in public health/prevention is similarly vital. There are many examples of how to do this. One is preventing falls in the home by occupational therapists ensuring there are no trip hazards which has a direct impact on the continuing well being of the elderly, as well as saving GP/hospital visits. This is a low cost, highly effective intervention that should be considered by all ICSs, including in privately owned housing. There is an education element to this too e.g. avoiding coffee cup scalds on children. Public health and education remain key pillars in the overall system notwithstanding funding challenges in recent years.

3. The Government Green Paper and proposals on social care is long awaited, but in the meantime public sector bodies should be considering the most effective use of current resources. There is also a real issue of underutilised space in hospitals and other settings which could be transformed for clinical use and used more intensively. It is understood that HM Treasury may want to announce some form of Dilnot style cap in the Queen's speech on 11 May and that will obviously change the Government sector involvement in private paid social care. Whilst this is perhaps a good thing for many in offering a degree of certainty about lifetime care costs, it does mean the Government is now arguably interested in making sure people progress more slowly against whatever cap that is. It is hoped this will mean the Government interest in prevention increases, rather than a single focus on the NHS. That could be a very interesting driver. As a result both Covid and the outfall of social care funding reforms together present opportunities for change.

4. The private sector contribution should not be ignored, retirement villages i.e. housing providing a level of care and support as needed is a model widely adopted in other developed economies such as the US and New Zealand. Very different from granny flats and care homes, this private pay sector again makes a major contribution to the continued good mental and physical health of its residents, who have far fewer visits to the GP and other calls on the NHS than similar aged individuals in non specialist housing. It is a sector which creates the investment in prevention touched on above. Whilst some NHS Trusts have sold land for development as residential villages, a more common NHS response is to object to the planning application on grounds that are often not reflective of the reality (people don't move to a new location to live in a care village, they are already there), which as can be seen is actually counterproductive to delivery of better health outcomes and making savings on the NHS budget. To this end it is a real positive that the White Paper mentions housing and this must be further leveraged. There is plenty of private capital around keen to invest in these opportunities which help to support the NHS and population health. This sector is not seeking Government money at all, but will benefit from Government assistance with creating elements of clarity where wider regulation overlaps with it.

5. There was some good discussion about doing things at the right level – place may be important, say, at a London Borough level, but delivery of complex acute services like stroke need to be organised on a larger geographical base, which is where the ICSs and higher level commissioning come in. But there is a tension, local leadership can enable quick and effective delivery, but how does the voluntary sector (including housing associations) engage with health? How do you have an effective voice and an effective decision making or consultative body without endless governance as the outgoing chief executive of UCLH asked in national media, how do you stop that governance from killing off activity at the different levels? Things are only going to happen if the right culture and the right leadership and the right relationships are in place. That takes a lot of groundwork and there are going to be some places where it is more challenging than others because of existing history, relationships and connections. This is a challenge identified as the NHS moved to the STP and ICS model and will remain so, but the opportunities are significant.

6. Linked to this, was a feeling that in some respects the White Paper proposals had not been fully socialised with the voluntary sector. This created a potential challenge, a lack of co-production could prevent buy-in, or the effective involvement of key parts of the health and social care sector, making the new system more challenging to implement nationally, regionally and locally. NHS England and NHS Improvement have signed up to a vision of involving the voluntary sector when thinking about system re-design in order to make the very best out of the voluntary sector, including the smaller, specialist charities that can sometimes be left behind in these bigger, wider scale initiatives. The process of moving away from competition and putting much greater emphasis on relationships does bring challenges, both for those statutory system partners to be thinking through, i.e. what is their leadership role in enabling other parts of the health system, and in the voluntary sector, social care and, housing to step in and consider what might need to be done to change or adapt. There is also a challenge for the voluntary sector to consider how it organises itself. It is by its nature fragmented, with lots of voices. The sector must find a way to communicate and seek a meeting of minds, both nationally and locally. In terms of the implementation of the policy ambitions, there are opportunities for infrastructures to work together, and opportunities to broker some of the relationships that will need to be formed in order to create effective, pathways and person centred commissioning and provision of services for local communities.

7. This was supported by other large national voices, sector participants need to think about place-based systems but also about the relevance of non placed-based conversations. It is important to ensure place-based planning, commissioning and delivery has an output that speaks to the strategic players in the big organisations who have got a lot of muscle in the system, but are not confined to activity in that one place, and who could respond by building housing or care homes or all those things that the local system is looking for. Successful partnership working also requires a pooling of resources and there is no sense of pooled funding in the White Paper which needs to be part of the conversation as it moves forward. Several of our round table participants have experience organisationally of working with or for people who have a lifetime need for social care, and not just a on—off intervention or an increasing need as they age. All of these kinds of provision drive different kinds of sector responses. The sector therefore needs to make sure that integrated structures create a whole system capable of reacting appropriately to each. That is a wide-ranging and challenging conversation but a key one to creating the intended outcomes of the White Paper.

8. Linked to all of the NHS reforms are the procurement reforms which are proposing to carve out health care services from the Public Contracts Regulations. It is proposed that the new NHS Provider Selection Regime will deal with health care services going forward and everything else that the NHS procures which are not health care related such as works, supplies and non health related services are still going to be caught by the PCR and the wider reforms. The NHS Provider Selection Regime is a bespoke system for the NHS which will affect three types of service provision. The first one is continuing with an existing provider and allows that relationship to continue where incumbent providers are doing a good job or they are the only viable provider for those types of services. Secondly, it will apply where the services have changed or the incumbent is unable to provide them and there is a need to identify a new provider (not through a tendering process, simply through working out from the available pool of providers who is most suitable). Lastly is a competitive procurement so either it is not straightforward to establish who is most suitable and a form of competitive process is needed, or a decision has been made that it would be beneficial to test the market for those particular services.

9. In both the second and third scenario there is a need to apply a list of Key Criteria which include areas such as quality and innovation. There is also going to be a lot more transparency so there's going to be a need for publication of notices, there's going to be a lot more publication of data and also holding the decision making body accountable for the decisions that are made and publicly available. On both the provider and the commissioner side there are pros and cons for this new approach. From a commissioner's side it could be viewed as involving a lot more red tape, a lot more notices and a more detailed audit trail. From the provider side there could be a concern that this allows those that are commissioning services to carry on with contracts without as much visibility and accountability as they might have had before. And also the challenge process, whereas before we had the public contracts regulations and a decision maker could be held accountable, now it will only be possible to make representations to the decision maker, or to go to judicial review proceedings, which could be viewed as the proverbial sledge hammer to crack a nut.

10. There was support for the proposition of continuing to contract with and fund specialist centres of excellence. There was also a plea that where services are funded from the local authority and the NHS it can be extremely difficult because they are not very well integrated currently. Better integration seems likely to be driven by more effective strategic planning around contracts. A lot of the conversations with commissioners currently create a feeling of short termism and are not looking at the longer term picture. They can be very driven by the immediate cost. This can create inefficiencies in many ways. Firstly, it will not create the investment in prevention referred to above. Secondly it can in fact waste costs in the short term, where, for example, a service which is not quite right is used because it is less expensive, that fails and the actual costs of meeting the relevant need end up much higher than if the correct service was engaged from the outset. The costs here could be any or all of time, money and indeed human cost. This does not feel very aligned to the "getting it right first time" mantra the NHS has been keen to deploy in recent years.

11. As such there is a clear risk that if leaders across the system are not willing to continue to work hard to join up thinking – across the NHS and other providers, across commissioning, across private and public sectors and across health, social care and housing, the goals of the White Paper may not be met. A key will be having the right people around the table across all of these areas, and getting the balance right between effective representation and the number of voices in ICSs going forward.

Concluding thoughts from the Trowers & Hamlins team

This was a fascinating and engaging discussion with a truly diverse group of participants in the NHS and the wider health, social care and housing sectors. In our view effective outcomes of the kinds the White Paper drives towards require all of these voices and all of the thinking, innovation and service delivery opportunities they create to come together. One challenge is always that the NHS struggles with the many voices both inside and outside of it and that will remain a really interesting area to keep an eye on as the White Paper policies are rolled out. Striking an effective balance between many voices, the different funding regimes and competing fiscal and policy requirements is an inherent challenge and one to which the White Paper presents a fresh opportunity to tackle. As well as challenges there are opportunities. In particular the prevention agenda and efficiencies it can create through using housing, private sector prevention initiatives and technology to create efficiency and reduce demand on services shone through the discussions.

A final key theme which came out of the conversation was about pathways, and creating holistic pathways. A pathway will look very different to a person with an isolated health need, a longer term treatment need but with an end-point, a lifetime need arising from birth, or an evolving need arising from (for example) advancing age. The system must be able to create effective outcomes which are patient centred in all of these cases. The challenge for a care system is to have the right kinds of services in place and available to generate positive outcomes for everyone who engages with it. This is the real potential of integrated care systems being placed on a stronger statutory footing. Many things must come together locally for this to be successful, and the details are what will drive success. The legislative framework being proposed should enable this, not hinder it, and that should be welcomed.

We very much see the debate we had as a starting point and look forward to continuing the conversation.

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