Written evidence submitted by Keep Our NHS Public (HSC0819)

1. Introduction

1.1 Keep Our NHS Public (KONP) is a civil society group concerned to restore and protect the NHS as a comprehensive, publicly provided and publicly accountable health service, funded from public taxation and free at the point of use.

1.2 We are grateful for the opportunity to present evidence on the proposals put forward in the Government's White Paper "*Integration and Innovation: working together to improve health and social care*". We have a number of concerns about these proposals, namely:

- The risk of a democratic deficit;
- Increased central control despite assurances of more local decision making;
- The risk of prioritising constraint over collaboration;
- A shift of focus for the NHS from the provision of universal, comprehensive care towards 'demand' management;
- The risk that mere lip service will be given to redressing health inequalities;
- The increased presence and influence of private companies facilitated by Integrated Care Systems;
- The implications of repealing Section 75 of the Health and Social Care Act (2012) without dismantling the market in NHS services;
- The emphasis on deregulation at the risk of cronyism;
- New arrangements that will fragment and deskill the NHS workforce, with the possibility of deregulating some professions in future; and
- The source of the proposals.

2. Background

2.1 KONP is in favour of an integration of services and collaboration between service providers when this is in the best interests of patients, and supports the provision of universal, comprehensive healthcare based on social solidarity. However, the notion of 'integrated care' that underpins the current transformation of the NHS is different. In the context of the White Paper proposals, 'integrated care' and integrated care systems represent a reconfiguration of organisational relationships, not care delivery.

2.2 The Government's proposals largely support NHS England's (NHSE) plans for new care models, originally based on Accountable Care Organisations in the USA, but adapted to the UK context and now referred to as Integrated Care Systems (ICSs) and Integrated Care Providers. ICSs have been introduced at pace, despite the findings of the National Audit Office, for example, that neither government departments nor NHSE have provided robust evidence to show that 'integration', as planned, leads to better outcomes for patients, reduced need for hospital services, or sustainable financial savings.[1]

3. Our concerns

3.1 The White Paper, together with related NHSE documents (such as NHSE's own legislative proposals for implementing the NHS Long Term Plan),[2] signal far-reaching and fundamental changes to the NHS that will increase privatisation, deskill and demotivate the NHS workforce, and potentially restrict patients' access to services. More specifically our concerns relate to:

3.2 The risk of a 'democratic deficit'

3.2.1 The geographical size of ICSs, along with the mergers (and ultimately the abolition) of CCGs, will concentrate decision-making at a level that is remote from local populations. This will reduce focus on any specific local area, meaning a loss of ability to identify, contact and lobby the commissioning body on issues of concern to local communities. Despite the strong possibility that ICSs will make changes to local services, the proposals make little reference to public engagement or consultation. There is currently no commitment that ICS Board meetings will be open to the public and, anyway, given the geographical size of ICS, these are likely to be inaccessible for most citizens. For example, the Cheshire and Merseyside Health and Care Partnership, currently well on its way to becoming an ICS, covers a population of around 2.5 million.

3.2.3 In addition, there will be limited representation of (elected) local authorities (LAs) on ICS Boards. ICSs will be dual systems, each with:
- an ICS NHS Body that makes strategic and financial decisions, that apparently will have just one LA representative despite the ICS footprint potentially covering a number of LAs; and
- an ICS Health and Care Partnership that brings together providers, LAs and organisations with an interest in health and care, and is responsible for developing a plan to meet the system's health, public health, and social care needs.

The relationship between these two bodies is unclear, except that the NHS Body sets strategy, controls the purse strings, and is responsible for setting up the Health and Care Partnership.

3.2.4 We echo concerns expressed by the Local Government Association that within ICSs the partnership between LAs and the NHS will not be one of equals and that the wider perspective of LAs on the role of social care, public health, housing, early years and other local government functions will be lost in local strategies and plans.[3] This is particularly of concern as NHS plans stress the need to redress inequalities in health, and yet the local government perspective is crucial to addressing the social determinants of ill health.[4] [5]

3.3 Increased central control and less local accountability

3.3.1 The White Paper proposals will give extensive new powers to the Secretary of State for Health and Social Care, such as the power to issue directions to NHSE and to intervene at other levels of the health service, along with the ability to abolish arms-length health bodies, including NHSE, purely through secondary legislation.

3.3.2 Proposals also indicate increased central control for ICSs, despite assurances of more local decision-making. For example, the White Paper calls for the Secretary of State to be allowed to take a 'joint' role in the appointment of Chairs and CEOs to local NHS Boards.[6] It also proposes placing a duty to collaborate on NHS organisations and local authorities within an ICS, but gives the Secretary of State the ability to issue guidance as to what delivery of this duty means in practice. Moreover, while the Secretary of State will have new powers to intervene at an earlier point in local decisions about the opening or closing of NHS services (risking politicising local service decisions),[7] local authorities will lose their ability to refer reconfiguration decisions to the Secretary of State. This loss of local accountability compounds the democratic deficit referred to above.

3.4 Prioritising constraint over collaboration

3.4.1 As mentioned, the proposals aim to ensure the compliance of all NHS organisations within an ICS through a legal duty to collaborate, notably on meeting the ICS's financial objectives and "shared use of NHS resources". This will bind providers and local authorities to a plan written by the ICS NHS Body and to financial controls linked to that plan. In a context where the NHS five-year funding settlement for 2019/20 to 2023/24 was inadequate, even pre-Covid, to respond to all the challenges facing the NHS,[8] the proposed legal duty could be read as a duty to accept cutbacks in resources such as funding without question.

3.5 The shift in NHS priorities from meeting all individual clinical need to the management of patient 'demand'

3.5.1 The White Paper strongly supports a move to 'population health management' (PHM) to decide priorities and plan health services, despite little evidence for PHM's effectiveness. PHM originates in the USA where the term usually refers to individuals covered by a health insurance plan, or registered with a particular health provider. It is used, for example, for data-driven chronic disease management and lifestyle or health behaviour interventions.

3.5.2 Very broadly, PHM redirects focus from the provision of universal, comprehensive health care for all to the use of vast data sets to identify patients and potential patients within an ICS who are most at health risk (and who are most expensive), with a view to developing health improvement targets. This approach allows an ICS to prioritise attempts to reduce patient 'demand' over clinical need:[9] data sets are used to determine how much care will be provided and to set budgets accordingly so that NHS services can be reduced, with the growing likelihood that those who can afford it will resort to using the private sector.

3.5.3 The focus on digital and data-based systems is also creating burgeoning opportunities for profitable contracts for private and multinational companies (see 6, below).

3.6 The risk of giving lip service to addressing health inequalities

3.6.1 NHSE expects ICSs will use PHM to reduce health inequalities.[10] However, PHM has been criticised for taking a micro level approach to health inequalities rather than acting on the broader social determinants of health.[11] While the Government wants to bring local government resources under the control of the NHS in order to redress health inequalities and improve social care, public health and mental health, there are no specific plans to address these issues.

3.7 The increased presence and influence of private companies afforded by ICSs

3.7.1 The White Paper enables ICS Boards to include representatives from unaccountable private companies, allowing them to influence which services are delivered, where, and by whom. The Board of the ICS NHS Body can include unspecified "others determined locally", while the ICS Health and Care Partnership has an unspecified governance structure that "could be drawn from a number of sources including … independent sector partners and social care providers". Thus there are two routes for private sector organisations to play a role in ICS decision-making and governance. According to NHSE,

> "Provider organisations and *others* (our emphasis), through partnerships at place and in provider collaboratives, become a principal engine of transformation and should agree the future service model and structure of provision jointly through ICS governance".[12]

3.7.2 In addition, ICSs are hugely dependant for their development and on-going management on organisations accredited by NHSE and listed in the Health Systems Support Framework (HSSF). Currently, the HSSF lists 83 'third party suppliers', the vast majority of which are private companies, and most of these are multinationals such as Deloitte, Centene, Optum and McKinsey. Many of these companies are particularly well placed to win contracts in response to ICSs' dependence on digital technology, including tools for population health management. Among other concerns, this **allows a growing number of corporations access to vast amounts of patient data.**

3.8 Implications of repealing Section 75 of the Health and Social Care Act (2012)

3.8.1 The White Paper's proposals call for Section 75 of the Health and Social Care Act (HSCA 2012) and associated regulations to be repealed. This entails revoking the Procurement, Patient Choice and Competition Regulations (2013), so transforming the NHS from a regulated market to an unregulated one, with unforeseeable consequences.[13]

3.8.2 Repealing Section 75 also removes the NHS from Public Contract Regulations (2015), so allowing commissioners within an ICS to dispense with formal procurement processes. This has implications for the proper administration of public funds:
> "... the procurement rules applicable to NHS expenditure seek to ensure the integrity of the procedures for the award of contracts and the achievement of value for money in a manner consistent with the patients' interest. Suppressing procurement-related requirements could thus result in an erosion of the integrity and the efficiency of the system and, ultimately, in risks of maladministration of public funds."[14]

3.8.3 Removing procurement regulations will also remove safeguards regarding
- compliance with ILO Conventions (fundamental workers' rights),
- equalities,
- any social and environmental impact, and
- contractors' previous poor performance, and whether they are adequately equipped to do the job.

3.8.4 The only context in which we would support the repeal of Section 75 would be the ending of commercial contracting as the method of procurement for health services.

3.9 Deregulation and cronyism

3.9.1 While we are by no means in favour of unnecessary red tape, the Covid pandemic has shown how unregulated procurement can lead to cronyism and corruption in what remains a competitive market. The White Paper's proposal to scrap Section 75 of the HSCA (2012) simply deregulates without proposing any alternative controls to prevent corruption.

3.10 Undermining the NHS workforce

3.10.1The Government proposals suggest that ICSs will play an increasingly important role in reshaping the NHS workforce, with new employment models, and 'career pathways' for employees that span the entire system. The workforce will be 'agile' and ready to be flexibly deployed, with a new system of accreditation to allow staff to be sent to different sites and organisations across (and beyond) the ICS.

3.10.2 There is no mention of the potential implications of these proposals and whether, for example, they mark the end of the existing Agenda for Change scheme that ensures equal pay for equal work. Significantly, the NHSE engagement exercise "Developing the payment system for 20/21" suggests that "the majority of activity will be funded through locally agreed fixed payments rather than national prices", which again calls into question national agreements on wages, terms and conditions.[15] In addition, there is no consideration in the White Paper's proposals of how demands for 'agility' could undermine team building or place huge pressures on staff expected to migrate across an ICS. We have already indicated how large an ICS's geographical footprint can be.

3.10.3 The Government's proposals echo those of the NHS Interim People Plan that call for the creation of a different skill mix, with new roles and ways of working that exploit the opportunities offered by technology.[16] We are concerned that this approach may lead to the de-skilling of the workforce with potential implications for patient care. In practice, frontline health and care staff working in the community, often working on their own, going into people's homes, need higher levels of skills, not lower, to support and maintain safe practice. Moreover, deskilling the workforce, and undermining the independence and clinical judgement of practitioners runs counter to the need - more important than ever - to retain staff and convince potential recruits that work in the NHS offers job satisfaction and professional development.

2.10.4 The White Paper also proposes changes to the system of professional regulation. It argues that "over time and with changing technology" the risks faced by particular professions may change and so regulation (and even regulatory bodies) may not be necessary in future. This would mean little control over who becomes a practitioner or how their competence is assessed, with the consequence that the public could be put at risk. Deregulation would make it easier to replace qualified staff with less skilled workers. The combination of deregulation with increasing reliance on digitally driven decision-making will clearly facilitate the creation of a cheaper but down-skilled workforce.

3.11 The source of these proposals

3.11.1 The White Paper proposals for organisational reconfiguration described as 'integrated care' reflect a multi-stakeholder initiative first promoted by the World Economic Forum in 2013 and very much in the interests of global healthcare corporations. The ideas from the WEF have subsequently informed plans for the NHS, notably NHSE's "Five Year Forward View",[17] its "Long Term Plan",[18] and now the Government's White Paper. However, there is no evidence that these ideas work. Instead they seem largely to benefit sections of the private sector seeking lucrative contracts and data. No MP or constituent has called for anything like this while the public has not been told of these plans, and is being denied a voice on the proposed changes at local and national level.

4. In conclusion

4.1 We believe that, far from being just another reorganisation of NHS bureaucracy, the White Paper potentially represents a huge reshaping of the NHS and one of the final steps in its fragmentation and privatisation. The public is totally unaware that this step is being taken.

4.2 We would urge the Committee to demand an immediate halt to the current roll out of ICSs and to consider whether these new bodies should really be given statutory powers through new legislation that would kill off what local level accountability still exists. There is a strong case for delaying the process of formalising the existence of ICSs pending an extensive and meaningful consultation with the public, health service staff and their unions, local authorities and Parliament to decide how health and social care services should be provided in England.

Contact: Dr John Puntis, Co-Chair, Keep Our NHS Public
john.puntis@yahoo.co.uk

[1] https://www.nao.org.uk/report/health-and-social-care-integration/
[2] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/02/nhs-legislation-engagement-document.pdf
[3] https://www.local.gov.uk/parliament/briefings-and-responses/integrating-care-next-steps-building-strong-and-effective
[4] https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on
[5] https://www.health.org.uk/publications/build-back-fairer-the-covid-19-marmot-review
[6] https://www.hsj.co.uk/policy-and-regulation/government-to-take-joint-role-in-appointing-nhs-chairs-and-ceos/7029728.article
[7] https://www.kingsfund.org.uk/publications/health-social-care-white-paper-explained
[8] https://www.kingsfund.org.uk/projects/positions/nhs-funding?gclid=Cj0KCQjwutaCBhDfARIsAJHWnHt4EYj3kooNqwJI_TIdP046xT4GZ3NYthfItGdjqL-OwjeGvk2TEIYaAmctEALw_wcB%20%20%20%20Kings%20Fund.%20'NHS%20Funding:%20our%20position'.%20February%202021
[9] https://www.nuffieldtrust.org.uk/files/2019-01/nutj6871-age-uk-care-190130-web.pdf
[10] https://www.england.nhs.uk/integratedcare/phm/
[11] https://www.jstor.org/stable/45276644?read-now=1&seq=1#metadata_info_tab_contents
[12] https://www.england.nhs.uk/wp-content/uploads/2021/01/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems.pdf
[13] http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-and-social-care-committee/nhs-longterm-plan-legislative-proposals/written/97675.html
[14] ibid.
[15] https://improvement.nhs.uk/documents/6779/Developing_the_payment_system_for_2021-22.pdf
[16] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf
[17] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
[18] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

March 2021