THE SOCIALIST HEALTH ASSOCIATION'S RESPONSE TO "INTEGRATING CARE - Next steps to building strong and effective integrated care systems across England"

WHAT SHA WANTS TO SEE

A cooperative and democratic health and care system, fully funded through general taxation, free at the point of use, that eliminates the privatisation of clinical services.

SHA cannot support these proposals.

RESPONSES TO QUESTIONS

Q. Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?
SHA does not agree. Our many reasons are explained below.

Q. Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?
SHA does not have a view on this.

Q. Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?
There need to be national standards, locally delivered, matched to the needs of an area. Please see SHA's thinking on NHS democracy.

Q. Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?
NHSE, if it continues to exist, should plan for those requirements that are best planned at national level. These could include rare diseases and specialist services.

SHA's REASONS FOR REJECTING THE PROPOSALS.

Based around place
SHA supports the idea of services based on an area, reflecting the needs of that place. However, this document leaves place ill-defined.

Relationships with Local Authorities
There is poor legislative alignment of responsibilities of Local Authorities (LAs) and ICSs. This is an issue particularly with reference to Public Contract Regulations 2015, which will still apply to Local Authorities and could increase the regulatory burden on local government, create barriers to joint

planning arrangements, or result in inappropriate planning via an NHS channel as discussed elsewhere.[i]

Interactions with local government are alluded to but only vaguely described. For example, the document states '[the proposals] will in many areas provide an opportunity to align decision-making with local government' [*our emphasis*]. This is very weak. How will ICS's that do not align geographically with local authorities function in this respect? There is a clear risk that such multi-authority ICSs will drive a 'one-size-fits-all' approach across diverse communities and geographies in direct opposition to the stated aims of 'decisions taken closer to the communities' [para 1.9].

Overall, it looks as though this is not a collaboration of equals. An ICS as described would be led by the NHS and the LA would be very much a secondary partner. The SHA would like to see a bigger and more equitable role for LAs.

Devolution
The statements on devolution such as at 1.11 can be applauded but the reality we know is that since 2011 the NHS has become more centralised. There needs to be more concrete proposals on how this devolution will occur. The mandatory nature of the proposals is a concern and there should be more local discretion within National Care Frameworks and oversight.

Governance
Clauses 1.12 and 1.15 are good clear summaries of what the ICS should do and provide. However, 1.16 on page 7 states that primary care, community health and mental health services, social care and support, community diagnostics, urgent and emergency care will be working together with other public or voluntary services Including those providing skills training, assistance into employment, and housing. But no consistent mechanism, structure, governance, regulatory, or accountability framework is defined for this.

Strategic commissioning/planning (P2, third bullet point) requires the resources of a CCG and of a CSU, but the proposal appears to leave the CSU as a separate organisation (see P24, 2.68) outside of the ICS. No explanation is given for why this is better. Our view is that the CSUs were created outside of the NHS to provide a first landing place in the UK for US insurers who failed to take up the challenge. The most cost-effective route to back office services and business intelligence would be to bring them back into the NHS as shared services operations.

These clauses do nothing to strengthen the requirement for probity in contracting and appointment procedures made scandalously apparent through court actions presently being pursued in the wake of inappropriate commissioning during Covid.

There are poorly delineated internal and external accountability processes. As others have noted[ii, iii] this is a consequence of a lack of precision regarding the function, roles and relationships of ICS. These issues should be clarified.

There is insufficient detail regarding the openness and transparency of appointments, decision-making and data sharing by ICS and the role of independent sector (IS) organisations in ICSs**.** While we note that the Government considered 'it likely that statutory organisations will hold the ICP Contracts'. [iv] Our understanding is that 'accredited' companies can be brought in to draw up policies and make service decisions within ICSs. These services could include:

- Enterprise-wide Electronic Patient Records Systems – for Acute & Community and for Mental Health Hospitals

- Local health and care record strategy and implementation support and infrastructure
- ICT infrastructure support and strategic ICT services
- Informatics, analytics, digital tools to support system planning, assurance and evaluation
- Informatics, analytics, digital tools to support care coordination, risk stratification and decision support
- Transformation and change support
- Patient empowerment and activation
- Demand management and capacity planning support
- System assurance support
- Medicines optimisation

The role of independent sector organizations in this context must be more clearly defined and regulated, and subject to governance appropriate to a public body. Where possible the NHS should provide such services and/or be empowered to provide any such expertise. We do not agree with private companies being brought in as decision makers. They are bound by law to maximise shareholder profit, not to provide a public service.

In addition, the document does not address the potential difficulties arising from the requirement on ICS organisations to comply with various competition rules, such as not sharing commercial sensitive information or fixing prices. For multi-site ICS providers, this presents a system risk in terms of having to share patient and staff data or information with other organisations. In general, insufficient attention is given to issues around sharing personal health information by ICSs.

Guidance should be also clearer on the overriding importance of transparency in ICSs decision making. Efforts should be made to limit the use of 'commercially sensitivity' as a spurious justification for subverting transparency.

There is insufficient consideration of potential conflicts of interest within the proposed ICS (e.g. between providers and commissioners, or between public, voluntary, and commercial partners) and how these can be prevented or mitigated. Notably it has been suggested that providers will be able to influence allocations via the ICS partnership board, and there is a credible concern that 'bigger players' will skew funding decisions.[v]

Governance and PCNs

1.17 mentions PCNs but the regulatory framework through OfSted for children's services, CQC, NHSE/I, is currently not fit for purpose because it is overlapping and contradictory. There is no governance framework at the moment for PCN collaborations with community and mental health Trusts, and accountability is difficult to pin down.

Data

The paper promises to invest in the infrastructure needed to deliver on the transformation plan. This will include shared contracts and platforms to increase resiliency, digitise operational services and create efficiencies, from shared data centres to common EPRs.

Digital is essential to the current and future NHS. SHA warns against the vaunted flexibility of the transformation plan allowing personal data to be misused by commercial interests even more than it is now. SHA also warns against services rushing into digital solutions without adequate evaluation and without enabling non-digital solutions for those who still require them.

Health Creation is not mentioned in this paper.
SHA supports the concept of Health Creation. That is the process of bringing people in contact with each other, building confidence and thereby enabling communities to take more control of their area and their health and care.

An option we would like to see would be mandating 1% of a PCN's budget to community strengthening – population Health Creation

Population health, but almost no mention of Health Inequalities
There needs to be a clear vision of the metrics of "population health" especially if this it to be the main outcome or "productivity" upon which the NHS and its partners is being judged. The consultation paper seems silent both on what these metrics are and on what role the NHS is to play in delivering that outcome. For example, is the metric of population health a pre-determined blend of longevity and the quality of life delivered? To what extent is managing the " social determinants of health" to be allied with the NHS as opposed to being the task of wider government and indeed others?

"Integrating Care" does not really explain "population health", but the HSSF is more explicit:
"Population Health Management is an approach aimed at improving the health of an entire population and improves population health by data driven planning and delivery of care to achieve maximum impact for the population."

Any concept of patients and staff planning and evaluating the service, which will involve decisions on what to prioritise, is absent. Instead, the HSSF accredits corporations to support an ICS in taking such decisions. We should propose a 5th principle on the necessary need to involve patients in these arrangements. There is good evidence that such effective engagements lead to better services.

In practice the emphasis on the role of Foundation Trusts and clinician-leadership is likely to prioritise clinical service provision, whether primary or secondary care, with limited focus on prevention and population health. This is an inherent structural weakness of the ICS model as currently specified.

SHA cannot support ICSs without a far clearer commitment to tackling health inequalities through tackling the wider determinants of health and working closely with LAs, housing and other key partners. The document states that greater co-ordination between providers at scale can support… 'reduction of health inequalities, with fair and equal access across sites;'. It is not clear how this follows as no mechanism linking these two is articulated. Vague commitments as outlined in the document are inadequate to address this persistent and worsening problem. Specific goals and mechanisms for reducing health inequalities should be explicit in the proposals.

Single pot for finance and the legislative proposals
On the face of it, a single pot (2.40), linked with reducing the importance of competition seems like a significant step forward and a more equitable and efficient approach to funding. SHA is supportive to the extent that these proposals reduce the contract negotiation and monitoring which is so wasteful of time and effort in the NHS, with savings in overhead costs and improvement in services designed by providers aiming at better outcomes, not by commissioners principally aiming to reduce expenditure. There must be appropriate risk sharing because of the danger that an individual ICS could be destabilised by unforeseen and one off events.

It is not clear how this single pot will be spent, assuring fairness, value for money, quality.

At 2.47 there is a limited mention of capital. There is no mention in the document of NHS Property Services or Community Health Partnerships or the NHS Estate. This is a major weaknesses in the proposals.

Taken together with *"Integrating Care"*, this makes clear that fixed payment to secondary care providers must conform to the ICS system plan. Initially , the fixed payment would be based on the current block payments under the heading of COVID-19, which make up the majority of current CCG budgets. Fixed payments will be determined locally. While national tariffs will no longer apply in general, they may be retained for diagnostic imaging, a highly privatised sector. Some elective activity, again involving the private sector, will also be exempt from blended payment. In other words, private sector suppliers of clinical services will be protected from any local cost reductions.

However, we also see impossible control totals which will make investing and innovation extremely difficult and constrain ICSs for the future. In effect, this continues austerity. We want to see comprehensive funding for an expanding, publicly funded NHS.

Allusion is frequently made to anticipated cost savings and efficiency improvements [paras 1.8, 1.9, 2.22, 2.46, 2.51] but it is unlikely that these will be realised in the short-term and short-term costs may even increase.[vi] Evidence from similar interventions in the UK and other countries provides at best equivocal evidence for longer-term improvements in efficiency.[vii, viii, ix] Quality rather than cost-savings should be the primary driver of any reorganisation.

There are other concerns SHA has in respect of the apparent relaxation of privatisation.
All clinical services should be retained in house and fall under a re-instated duty of the Secretary of State for Health to PROVIDE such services.

Providers will still be able to use the private sector. There are contracts now through NHS Shared Business Services which appear to require no formal tendering.

Beware of cementing existing privatisation. This can happen through sub-contracting as above and by current private sector providers expanding through what ever contracting process there may be. The most likely beneficiary is likely to be the privatisation of mental health services through the Priory and similar organisations.

Backroom functions will continue to be privatised.

"Integrating Care" never mentions "private", "independent sector" or "third sector". The document uses a new codeword, namely 'others'. This suggests that NHSE fully expects the private sector to play a most important part in the future, including for clinical services. (**NHSE/I** "Integrating Care" KONP)

Covid has shown us, if we needed showing, that a truly nationalised health and social care service is needed and vital, with the advantages of national estate agility, workforce planning, driven by a national public health strategy to invest in the social care infrastructure of the national economy, whilst local partnerships freed of wasteful market practices are responsible for local delivery and can be locally accountable.

Staff
Whilst the fixed payment would be determined locally, neither *"Integrating Care"* nor *"Developing the payment system"* refer to national agreements on wages, terms and conditions.

The SHA is very concerned that, despite papers on responding to the staffing problems, we have not seen any recommendations for comprehensive staffing programmes that support pay justice and adequately protect workers.

Despite discussion emphasizing the key role of the workforce in effecting these changes, mechanisms to allow direct representation of workers or their trade union spokespersons on ICS are entirely lacking in the proposals.

Any proposal for ICSs should make explicit commitments to ensuring that all workers receive the National Living Wage (and preferably the real Living Wage) whether they are employed by the NHS or by subcontractors to ICSs. ICSs should commit to abolition of zero hours contracts in all its activities.

Democracy
Despite frequent criticism of ICSs as being distant from communities and undemocratic (as indeed is the NHS as a whole), this paper gives little confidence for any significant democratic change. Healthwatch is not sufficient, too health focused and with too few teeth.

SHA would like to see financial transparency, accountable to communities. SHA would like to see ICSs exploring the opportunities for participatory democracy – such as community development, citizens forums, coproduction networks.

"Current ICS arrangements are outrageously disconnected not only from real democratic structures but also from real centres of identity and community. They are administratively defined and they are under the control of officers who are not accountable to local people.

What I would like to see is NHS Sheffield accountable to the local people of Sheffield (and likewise for other communities). It is totally inappropriate to leave accountability and governance of supposedly statutory bodies open to development and interpretation by officers of the ICS. All the assets of the ICS should be treated as public assets, especially all the capital assets and these must all be put under local (not national) control." Duffy, SHA member

With many thanks to all those SHA members who generously contributed to this response. We have also drawn on documents from Keep Our NHS Public and the Local Government Association.

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[i] Integrating care: Next steps to building strong and effective integrated care systems. Local Government Association (https://www.local.gov.uk/parliament/briefings-and-responses/integrating-care-next-steps-building-strong-and-effective accessed 23/12/20)
[ii] Delivering together: Developing effective accountability in integrated care systems. NHS Confederation/Solace (https://www.nhsconfed.org/-/media/Confederation/Files/Publications/Delivering-together-FNL.pdf accessed 22/12/20)
[iii] Integrated care systems (ICSs) (https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/integration/integrated-care-systems-icss accessed 24/23/20)
[iv] Government response to the recommendations of the Health and Social Care Committee's inquiry into 'Integrated care: organisations, partnerships and systems' Cm 9695 (https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwiJw-_Dt-ztAhWkoVwKHXuRAkIQFjAAegQIARAC&url=https%3A%2F%2Fwww.gov.uk%2Fgovernment%2Fpubli

cations%2Fgovernment-response-to-the-health-and-social-care-committees-report-on-integrated-care&usg=AOvVaw2k1pzGscqk30BYEL_QbNJt accessed 26/12/20)

[v] On the day briefing: Integrating care, NHS England and NHS Improvement. NHSProviders 26 November 2020 (https://nhsproviders.org/media/690689/201126-nhs-providers-on-the-day-briefing-integrating-care.pdf accessed 26/12/20)

[vi] House of Commons Health and Social Care Committee Integrated care: organisations, partnerships and systems Seventh Report of Session 2017–19 (https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwjb-oSstuztAhUNYsAKHabDDoYQFjAAegQIBBAC&url=https%3A%2F%2Fpublications.parliament.uk%2Fpa%2Fcm201719%2Fcmselect%2Fcmhealth%2F650%2F650.pdf%3Futm_source%3DThe%2520King%2527s%2520Fund%2520newsletters%2520%2528main%2520account%2529%26utm_medium%3Demail%26utm_campaign%3D9379676_NEWSL_ICB%25202018-06-13%26dm_i%3D21A8%2C5L1EK%2COYZ6AS%2CM5X8X%2C1&usg=AOvVaw0-ZVcp3j_Sh049yv9kdNTA accessed 26/12/20)

[vii] John Lister, How Keep Our NHS Public should be campaigning on Integrated Care Systems. November 24 2020. (https://keepournhspublic.com/resources/how-keep-our-nhs-public-should-be-campaigning-on-integrated-care-systems/ accessed 26/12 20)

[viii] Government response to the recommendations of the Health and Social Care Committee's inquiry into 'Integrated care: organisations, partnerships and systems' Cm 9695 (https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwiJw-_Dt-ztAhWkoVwKHXuRAkIQFjAAegQIARAC&url=https%3A%2F%2Fwww.gov.uk%2Fgovernment%2Fpublications%2Fgovernment-response-to-the-health-and-social-care-committees-report-on-integrated-care&usg=AOvVaw2k1pzGscqk30BYEL_QbNJt accessed 26/12/20)

[ix] Scobie S (2019) 'Are patients benefitting from better integrated care?', QualityWatch blog. Nuffield Trust and Health Foundation. (www.nuffieldtrust.org.uk/news-item/are-patients-benefiting-from-better-integrated-care accessed 26/12/20)