JHOSC, 19 March 2021 - Deputation on ICSs - Integration and innovation? *NCL NHS Watch*

Introduction

Since our presentation to JHOSC in January about proposals in NHSE's proposals for ICSs, ***Integrating Care -next steps to building strong and effective care across England,*** the government published a **White Paper (WP), *Integration and innovation: working together to improve health and social care for all*,** proposing legislation this Spring to give Integrated Care Systems (ICSs) a legal basis by 2022. The ICS will bring together primary, secondary, and public health, with social care, under the ICS (i.e. NHS) management, with a single, capped budget.

Omissions, context, over-claiming and the *'new normal'*
Neither document addresses the real keys to improving health outcomes and reducing health inequalities i.e., redressing the ***workforce and funding issues in health,*** relative to comparable countries, (fewer beds, doctors, and nurses), social care and public health. The context is one of ***councils weakened*** by cutbacks and erosion of powers, reductions in all areas impacting the social determinants of health, and a ***developed, private health care sector*** of pre-approved companies.

The White Paper claims that its proposals are essential now. It states '***the response to Covid 19…..has shown us new ways to deliver care using ……. the potential of digital and data instead of needless bureaucracy. We must not go back to the old ways of working. The gains made by these new approaches must be locked in*'**. Yet many of these new ways of working trouble councillors and patients. ***Claims that the proposals will reduce bureaucracy, end competition, and promote collaboration and partnership are not substantiated with detail or evidence.***

Key issues for Councillors and the public *are:*

1. **unequal partnership and lack of representation**
2. **reliance on digitisation and shift to data driven, virtual, remote care**
3. **threats to councils' role and funding for social care and public health**
4. **unscrutinised, wasteful procurement**
5. **Integration – structural and financial - not patient centred**

1.Unequal partnership and lack of representation, accountability, transparency, and engagement for councillors, users, and the public

*'We will work much more closely with local government', y*et ***local government bodies were not involved*** in drawing up the proposals and are still not being involved; the ***LGA*** voiced concerns about the ***unequal partnership between councils and the ICS,*** and the ***BMA*** about the ***risk of reduced clinical involvement in decision making.*** Councils will also ***lose a significant power*** to refer proposed reconfiguration of services to the Secretary of State, used to good effect in recent years.

The new structure includes ***two boards****:*
ICS NHS board responsible for ***spend and performance of the system, to run the ICS***. It will have a chair, CEO and representatives from NHS trusts, primary care and local authorities and 'others'. It will not have the power to direct providers. Currently ***NCL ICS has one LA representative***, the Haringey CEO and the merged CCG only ***non-voting LA representatives***.
ICS Health and Care Partnership Board composed of NHS, local authority and other partners focused mainly on social care, and public health needs of the system, and is subordinate to the ICS NHS Board. Neither NHS bodies nor Local Authorities will be bound by ICS Health and Care Partnership Board policies.

Mandated collaboration, joint capped budgets, conflicts of interest and no veto
The ICS will work to a ***single plan and single budget*** and its proposals will be binding with no veto. Partners will have a duty to collaborate and be ***collectively accountable*** for delivering the plan and budget and the ***Triple Aim*** of better patient care, health, and sustainable NHS resource use. The NHS ICS will be able to establish committees and delegate functions to individual or groups of providers and its committees can make legally binding decisions on major resource allocation and service provision. With independent providers on boards, there is potential for major ***conflicts of interest*** and under/***unscrutinised/ lack of due diligence in awarding contracts***. The ***BMA*** highlighted this concern, and the ***lack of an NHS Preferred Provider*** specification.

The ICS board will be ***accountable upwards*** to NHS England and now the Secretary of State, but ***not to the public, patients, carers, or Local Authorities***. There is no detail yet that requires ICS boards to meet in public, publish board papers or minutes, or it seems be the subject to FoI requests. Private providers are not bound by FoIs unless this is included in their contract - which is rare. It has not been made clear what ***powers the ICS NHS would have over local authority assets*** including proposals for the Better Care Fund and powers over local public health.

These mandated powers over the NHS and LAs, with their different funding and accountability mechanisms, ***misses the opportunity t***o foster genuine public accountability and engagement between the NHS, LAs and the public that exists in some areas.

2.Digital, data, and the vanishing doctor/patient relationship

The use of ***digitization*** to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care is a ***key plank of ICSs***, and the use of digital technology to reimagine care pathways. *(Integrating Care).* North London Partners (NLP) aim for 2020/21 is that ***'the use of online and video consultation is embedded and normalised across NCL by both patients and GPs.'***

Their only concern is managing or coaching the 'digitally excluded'. There is no recognition that the shift to ***virtual and remote consultations,*** instead of face to face meetings with health professionals, erodes the ***doctor patient relationship,*** which robust evidence indicates is key to better patient outcomes, including diagnosis, treatment compliance, and the importance of ***relationship continuity*** to reducing mortality. *(1)* A blended approach of virtual/ remote and face to face contact, with the latter enshrined as a right *can* offer greater convenience and patient choice, but as an addition, not with f***ace to face increasingly the exception or attracting lengthier wait times.***

Given the chronic shortage of GPs, with no realistic plans to redress this, it is easy to understand the emphasis on increased remote access, the involvement of other health professionals and social prescribing, as cheap, quick means to ***mask the GP shortage***, rather than increasing contact and treatment options for patients.

Data driven, actuarial targets and the vanishing patient
Improving the health of the population and reducing variations within an ICS, will depend on ***data driven planning*** between NHS and LAs, using Population Health Management (PHM). PHM is critical for the ICS model, relying on ***data sharing*** across care settings, the move to ***remote consultation, triaged by algorithms***, and shifting the focus from care for individual patients, to data driven, actuarial health targets for the whole population. However, ***targets set nationally,*** or by an ICS board, particularly one with provider interest, may ***not be good for an individual patient.***

Public health has long produced ***JSNAs,*** and evidence on how to combat health inequalities is not new; what has been lacking is funding and national political will. So, it is unclear how the ICSs PHM

approach can deliver better public health, in the context of an over 33%, and continuing, cut to councils' funding, impacting services, essential to addressing health inequalities.

3.Social care, public health, and council democracy under threat

Major ***social care proposals are deferred*** to later this year. There is no acknowledgment of Social Care's (SC) remit for a wide group of people with a range of need, disability, illness, or frailty, but solely its role in meeting the NHS's hospital discharge targets. The ***Discharge to Assess*** model will be updated, whereby ***assessment take place after an individual is discharged*** from acute care. There is also no acknowledgment of the emphasis in SC of ***co-production*** –and what this would mean for governance arrangements.

The plans for ***Public Health*** (PH) are sparse and mainly relate to restrictions on food advertising and labelling, to tackle obesity.

LA's responsibilities for SC have already been eroded by the Care ***Act Easements 2020,*** and now the Secretary of State (SoS) has powers to directly make payments to SC providers. ***'Not only will the local government voice be relatively weak, but the powers given to the SoS could see councils losing control of their SC and PH services to the priorities of the ICSs. In those circumstances, it would no longer be clear what the purpose of democratic local government might be'.*** *(2)*

4.Unscrutinised and wasteful procurement

Increased data sharing means large contracts for private companies. The White Paper proposals to repeal competition law as it applied in the Health and Social Care Act 2021, and its accompanying system of procurement, increases the prospect of **unregulated direct awarding of contracts, *an even worse prospect than the previous competitive regime.*** This occurred during the pandemic, as highlighted in the ruling of the High Court against the Secretary of State, and locally, the recent renewal of a contract by ***NCLCCG Primary Care Committee***, handing several NCL ***GP practices,*** previously owned by AT Medics, ***to a US company***, Operose, owned by Centene, without transparent due diligence or consultation with local authorities. All five lead members for Health & Social Care in NCL have made a formal protest about this.

There are also 101 global, US and other accountancy, digital technology and health care companies, already signed up in the Health Support Service Framework, a ***pre-approved list of companies*** which can be awarded contracts with no further tendering or competition available to ICSs.

5.Integration -structural and financial – not patient centred

Integration conjures up visions of coordinated, wrap-around patient care, but this is not the plan. ***Structural and financial integration*** is a central goal of the NHS Long-term Plan (2019), as a means of ***saving money*** by reducing hospital bed occupancy, secondary referrals, and GP face to face contacts. The WP claims that integration can only happen with this Bill, but different forms of integration and collaborative, working at patient and local level have developed before, without this legislation and ICSs.

The National Audit Office noted that the *government had* ***not yet established a robust evidence base to show that structural integration leads to better outcomes for patients*** and that there was no compelling evidence to show that integration in England leads to sustainable financial savings or reduced hospital activity. (*3)* Previous government ***mandated collaboration imperatives*** have ***foundered*** on the different NHS/LA funding and accountability regimes, which the WP does not successfully address.

Next steps – we urge the JHOSC to:

- ***raise these concerns*** with NCL, the mayor, local government bodies, MPs
- press for full, public ***consultation*** involving all stakeholders before further implementation.
- insist NHS and local authorities have ***parity of representation and voting rights on main ICS board***
- demand measures to ensure ICSs are fully ***accountable to LAs, public,*** users and carers and meetings to be held and papers/minutes etc to be made public
- insist that face to face consultations are enshrined a right, not a rationed exception -***Patient First not Digital First***
- press for ***independent providers to be excluded*** from membership on decision-making/resource allocation boards
- insist ICSs to be prohibited from purchasing services from their board members.
- demand changes that will make a real improvement to ***health outcomes and inequalities***.

References:

1.Pereira Gray DJ, et al, Continuity of care with doctors -a matter of life and death? A systematic review of continuity of care and mortality. BMJ Open 2018. 10.1136/bmjopen-2017-021161)

2. (Hudson R, Short on detail but not on ambition: four problems with the new NHS white paper. British Politics and Policy, LSE, March 7, 2021)

3. https://www.nao.org.uk/wp-content/uploads/2017/02/Health-and-social-care-integration.pdf .

Brenda Allan, Alan Morton, NCL NHS Watch