JHOSC June 25th 2021
Deputation on the White Paper -integration and innovation and primary care post - Centene

Since our delegation to the March JHOSC, more details about the White Paper have been released which confirmed our concerns.

The Government plans to put the Bill formally establishing the ICSs across England before Parliament in the next few days. As this will happen shortly before the end of the Parliamentary Session, there will be no effective scrutiny of the Bill its provisions. We feel this is deliberate on the part of the Government and NHSE to avoid thorough examination of their proposals. This makes it even more important that JHOSC does that scrutiny.

We have looked more closely at some of the underlying issues for primary care (Item 6 below).

As was noted previously, some of the stated goals of the White Paper are laudable -e.g., promoting integration, reducing competitive tendering, partnership, collaboration, and tackling health inequalities. If the implementation of ICSs, and the context had been different, the proposals could have been very positive. However, as it stands, the White Paper does not address the real keys to improving health outcomes and reducing health inequalities i.e., workforce and funding in health, relative to comparable countries, (fewer beds, doctors, and nurses), Investing in social care and public health, and council cuts and reduced responsibilities.

- Ideally there would be a full public consultation involving all stakeholders, with implementation delayed till after the worst of the pandemic, as suggested by NHS Providers.

- The key concerns remain the same and we strongly recommend that the JHOSC raise these with NLP, the mayor, local government bodies and MPs and their own voters.

1.*Unequal partnership* between NHS and local authorities. The new ICS design framework details for ICS NHS board membership are a chief executive, nursing director, medical director, and a minimum of two other independent executive directors. NHSE also expects that boards will have three additional partner members, including one from the local NHS, one from general practice and one from social care. The ICS NHS board controls plans and budgets for the whole system.

There is no mention of representation for patients and public. There is no requirement that ICS boards meet in public, that board papers and minutes are published, nor that they be the subject to FoI requests, which given that private providers can be members of both the ICS NHS as well as Partnership Boards, is unsurprising, but retrograde for a public body.

As an example, the Bath, North East Somerset, Swindon and Wiltshire ICS has a Virgin Care director on their Partnership Board. Virgin Care was not prepared for any information to be shared with the public. In response the other board members agreed that the 'open book approach would need to be amended to protect providers' corporate and commercial interests.

- *JHOSC should press NCL to ensure councils and primary care have parity of representation and voting rights on main ICS board or at the very least, increased voting representation.*
- *Measures need to be in place to ensure ICSs are fully accountable to LAs, public, and patients, meetings to be held, and papers/minutes etc to be made, public, and ICSs be subject to FoIs.*
- *Independent providers should be excluded from membership on decision-making/resource allocation ICS board and committees.*

- *We also urge JHOSC to seek assurances from the NCL CCG that the role and remit of JHOSC will continue if and when an ICS is formally constituted in NCL*

2. The White Paper will repeal *competition law* as it applied to procurement, in section 75 of the Health and Social Care Act 2021 and exempt the NHS from the Public Contract Regulations safeguards for compliance with environmental, social, and labour law (ILO). Also with independent providers permitted on both ICS boards, there is potential for major conflicts of interest as highlighted by the BMA, *'the White Paper takes the first step to abolishing these wasteful rules, but unless it goes further -making the NHS the default option for delivering NHS services -there is a risk that contracts will be awarded without scrutiny to private providers at huge expense to the taxpayer, as was seen with the procurement of PPE and Test & trace during the pandemic'.*
The new *Provider Selection Regime* (PSR) consultation document permits contracts to be continued, directly selected or tendered - the former creating opportunities for private companies, e.g. Centene to be 'locked in'. There is also a developed, private health care sector of 200 plus pre-approved companies in NHS England's Health Support Service Framework.

- *We urge the JHOSC to press the ICS to agree that the NHS organisations be the preferred providers in NCL*
- *We strongly recommend that the JHOSC press the ICS to use the provisions in the PSR to continue or directly select existing NHS, and some not for profit providers, when contracts come for renewal, as these are better value for money with no funds diverted to profit and contracting costs, and all funds reinvested in the service.*

3.Major *social care (SC)* proposals are deferred again. The Discharge to Assess model will be updated, with assessments taking place *after* discharge from acute care, with an estimated 80% not receiving an assessment. Councils' responsibilities for SC have already been eroded by the Care Act Easements 2020, and now the Secretary of State (SoS) will be given powers to make direct payments to SC providers, and the CQC will gain new powers to assess councils' delivery of SC. The plans for *Public Health* (PH) are sparse and mainly relate to restrictions on food advertising and labelling, to tackle obesity.

- *Press for increased investment in public health and social care, with wholesale reform of the latter, to deliver significant improvement to health outcomes and inequalities.*

4. The Secretary of State can remove a *profession from regulation,* and abolish regulators; this opens the way for employment of a less skilled, lower paid workforce with poorer health outcomes for patients.
There appears no merit to these proposals which should be scrapped.

5. *Digitalisation* and technology are central to ICSs, to reimagine care pathways, with little acknowledgement that the huge shift to virtual and remote consultations, erodes the doctor patient relationship and continuity, key to better patient outcomes, not least to reducing mortality. The emphasis on data driven planning between NHS and councils, using Population Health Management (PHM), and data sharing, with poor safeguards, and actuarial health targets for the whole population, within a capped budget, is likely to result in further rationing and delays to healthcare.

- *Urge NCL to agree Face to face consultations are enshrined as a right, not a rationed/delayed exception - Patient First not Digital First.*
- *Introduction of capped budgets to be delayed or preferably scrapped -* there has always been the ability to roll over deficits and seek bailouts – but coming after years of lower level percentage annual funding increases, the impact of Covid 19, and NHSE's latest demand for savings, increased productivity and efficiency, and the restoration of 'normal financial disciplines', capped budgets will result in even more serious delays and rationing.

- *Press for government to increase funding to meet the backlog that existed before the pandemic, but exacerbated by it, and restore annual funding increases of 4%, and abolish the remaining components of the expensive and wasteful private market tendering provisions.*

6. Primary care

Primary care is under severe pressure and at breaking point, with patient satisfaction declining as a result because of the difficulties making contact with practices, getting appointments, long waits, telephone triage, and then long waits for referrals to secondary care.

Funding and workforce – These problems are unsurprising given that primary care provides 90 % of patient contacts but receives only 10 % of NHS funding. There was a 10% vacancy rate in the NHS pre-Covid which is now much worse, and for many years there have been Insufficient GP training places to cope with replacement needs and increased demand.

If general practice fails, so will the NHS, with patients diverting to emergency departments (ED) and other unscheduled care provision, but still the workload increases without concomitant funding. It is worth noting that a year's worth of GP care per patient costs less than two trips to EDs.

Pressures A range of pressures have resulted in early retirement, heavy workloads, demoralisation, difficulties for partners to buy in, and lack of career structure for salaried GPs. Because of these difficulties, many GPs both salaried and partners are vulnerable to leaving, giving up practices, which if they had received greater support, e.g. helped to merge or partner, gain economies of scale by sharing back office specialists e.g. HR, IT, complaints, compliance and premises management, and collaborate on service development, may well have continued.

Contracts NHSE made clear by 2014, that all new GP practices should be on Alternative Provider Medical Services contracts (APMS), i.e. contracts held by private companies or third sector organisations, other than GP partnerships. This has opened the door to the Centene type takeover. One of the difficulties for GP partnerships or even GP Federations when bidding for contracts, is that large multinationals have teams for contracting and can put in glossy, deceptively polished tender documents. They have threatened or actually sued, if they fail to win contracts - so tendering is not a level playing field.

KONP have put in an FoI to NLP requesting details of when contracts will come for renewal and are awaiting a response. There is also currently a Judicial Review pending on the Centene takeover.

Action –

1. We strongly recommend that the JHOSC **raise these concerns about funding, workforce and the use of APMS contracts with NLP, the mayor, local government bodies and MPs.**
2. **We urge the JHOSC to make clear to the NCL ICS that primary care on the standard GMS contract and the less common PMS one, should be supported and that APMS contract should not be used for primary care.**
3. **The JHOSC should explore with the ICS, the options for increasing support to GP practices, beyond that currently available from the Federations and PCNs.**
4. **They should also ensure primary care contracts remain within the NHS, perhaps with GP Federations, PCNs or local Trusts, and explore salaried GP practice options, rather than private APMS ones.**
5. We urge JHOSC to seek assurances from the NCL CCG that the role and remit of JHOSC will continue if and when an ICS is formally constituted in NCL.

Brenda Allan & Alan Morton NCL NHS Watch