

Submission to Health Select Committee Keep Our NHS Public (KONP)

1: Keep Our NHS Public (KONP) is a national campaigning body with over 100 affiliates including 78 local campaigning branches across England. It exists to promote an NHS which is publicly funded, publicly provided and publicly accountable, and available to all on the basis of clinical need rather than ability to pay. We are not affiliated to any political party. We were set up in 2005. The funding for our campaign comes from small donations and money raised by local groups.

2: Introduction

2.1: Your inquiry is into how current policies aimed at achieving greater integration between all parts of the health and social care system, as in Sustainability and Transformation Plans and Partnerships, ACSs and ACOs – including assessment of impact, governance, legislative context and public engagement – are working.

2.1: We believe that there is a danger that 'integration' is asserted to be the solution that is reached for whatever the problem exhibited, and that the publication of Simon Stevens' vision, the Five Year Forward View, has created a narrative on what is needed which fails to address some of the fundamental problems of the NHS – notably the level of funding per head of population, the staffing crisis and the near disintegration of the social care system. Although we are broadly in favour of close coordination between Health and Social Care, we believe that organisational and agency integration is not the solution to the major ills of the NHS, and hope that you will bear that in mind as you reflect on the evidence.

2.3: The NHS is commended by international foundations for the efficiency and value for money with which it approaches its work¹, having been until very recently light on market transaction costs. These escalated dramatically following the legal requirement since 2013 (with the implementation of the Health & Social Care Act 2012) to put NHS services out to competitive tender on a far wider scale than previously. Other payments are also incurred by the market (eg legal costs such as incurred by NHS Surrey CCGs in conflict with Virgin Care recently) that are characteristic of insurance based health care markets. Transaction costs have escalated

2.4: The proposal to make a significant shift in the balance of resources applied to acute and to primary care – 'community based care' – is the favourite recipe for cost cutting in health care promoted by international consultancies. But it is not axiomatic that the UK, which has markedly fewer acute beds per unit of population than most other advanced countries, should be taking this route.² Nor is it clear that more care outside acute settings will be any cheaper, provided the levels of skill and

¹ See Commonwealth Fund of America <http://www.commonwealthfund.org/publications/fund-reports/2017/may/international-profiles>

² Stewart Player 2016 <https://www.opendemocracy.net/ournhs/stewart-player/accountable-care-american-import-thats-last-thing-englands-nhs-needs>

qualification of those doing the caring remain the same. And as research has shown, the level of qualification of the person providing the health care does matter in whether desired outcomes are achieved.³ Good community based care is highly desirable, but there is a dearth of evidence that it can or should replace acute capacity on any significant scale, or that it is necessarily more efficient or cost-effective.

3: Evidence-based pre-requisites for effective community based care

3.1: In the Canterbury, New Zealand example, the successes in achieving a degree of admission avoidance and early discharge were achieved over a 10 year period, with no reduction in acute capacity (rather a better ability to use that capacity to cope with rising need). They were supported by significant investment in community staffing and resources and in staff training.⁴ None of the above prerequisites apply to the STP plans to be implemented via ACSs and ACOs rapidly, in an environment of severe cost-cutting, staff shortages and very low morale.

3.2: It should go without saying that good co-ordination between acute and primary health sectors is to be desired; that adequate funding of social care is needed to enable the NHS to achieve the right level of flow through from assessment and diagnosis, to treatment and return of patients into the community; and who could argue with the proposition that efforts to prevent ill-health and improve population well-being are worthwhile things to do.

3.3: We are concerned that the explicit motivation for the drastic reorganisation of the NHS outlined in the Five Year Forward View has been cost savings.

3.4: The bottom line message given to CCGs, NHS trusts and other NHS bodies is that the NHS has to be reorganised in such a way as to deliver a minimum of £22bn of cost avoidance by 2020 – to cope with £22bn underfunding relative to predicted need by 2021. This has already risen to approximately £26bn excluding recent Budget changes.

3.5: We argue that whatever the merits of some aspirations contained within the Five Year Forward View (such as the aim to develop excellent community based care), most of these are fatally undermined by this level of underfunding. And the evidence is simply not there to show that ACOs are the route to success.

3.6: The NHS has been underfunded by approximately 3% per year on average throughout the period 2010/11 to 2020/21. As the Committee has pointed out, the funding for NHS and Social Care has fallen well below what is needed to sustain these public services. In summary, the STPs have become a smokescreen,

³ Nuffield Trust 2011 Integrated care in the NHS <https://www.nuffieldtrust.org.uk/files/.../what-is-integrated-care-report-web-final.pdf>

⁴ Kings Fund, Developing Accountable Care Systems – Lessons from Canterbury, New Zealand, Anna Charles August 2017. https://www.kingsfund.org.uk/sites/default/files/2017-08/Developing_ACSs_final_digital_0.pdf

advocating integrated and community based care, where behind the smokescreen lies the reality of severe cuts.

4: Damaging 2012 reorganisation opened the NHS door wide to the market

4.1: It is now widely agreed that the 2012 Health and Social Care Act was a policy disaster. It represented a radical shift from a planned public service, with relatively marginal marketised clinical elements prior to that and markets predominantly in the provision of non-clinical services. The 2012 Act instead created a market for the core services and removed much of the public accountability for how the market operated. 'Did the experiment fail or was it never really tried?' - this is the question often posed by those who have advocated such revolutionary change. Whatever the answer, what we were left with was a transaction cost-heavy process, which fostered competitiveness between different parts of the health and social care system rather than collaboration, and was done through a very costly reorganisation – 'so big that it could be seen from space'.⁵ And as is shown by the large number of contracts which have been abandoned or which have fallen at a late stage of procurement, private companies find it hard to match the level of efficiency in the NHS while also making a profit.

4.2: Although there is widespread agreement about the need to change the market model, the 2012 legislation remains on the statute book. It is the law of the land. It still applies. CCGs are still required to contract out services and in most cases are doing so, with now 8% of clinical services delivered by the private sector, in addition to the subcontracting by NHS trusts to private hospitals for elective care. It is a broken market with fewer competitors and many failed and abandoned contracts which have taken up time and attention before they fell to earth.

5: The spectre of privatised management of the NHS by ACOs

5.1: The Government denies its policies are facilitating privatisation of the NHS. Reality proves them wrong: contract value for clinical services held by private companies is now over 8%.⁶ Virgin Care alone holds £2bn worth of over 400 health and social care contracts. £3.1bn in contracts went to private companies in the year to March 2017. The NHS was awarded less than 40% of clinical contracts in the last year. In this context we fear that the contracts to manage ACOs will also be tendered for and private companies – individually or in special purpose vehicles of wholly private or private-public partnerships – will win substantial numbers of such contracts, for 10-15 year periods.

5.2: The Government says this is crying wolf. But without the removal of the parts of the Act which call for compulsory tendering, the danger will always be there that any change brought about by STPs, ACSs or ACOs – bundling the NHS up into large but manageable portions with far larger revenue streams for one management organisation to control than ever – will simply create more attractive propositions to offer to the market. It is clear from reading the draft ACO contract and guidance put

⁵ Sir David Nicholson, NHS Alliance Conference, 18 November 2010

⁶ NHS For Sale, NHS Support Federation December 2017 <http://www.nhsforsale.info/contract-alert/contract-report-dec-2017.html>

out by NHSE in August 2017 that an ACO could be a private company, despite the protestations of many of the established think tanks that ACOs are not about privatisation. Instead of a detailed specification for a particular area of service which can in theory be monitored and contract-managed, the private sector could win an ACO contract, lasting for 10 or 15 years, a contract to deliver outcomes most of which could not be measured in the short term, and with huge discretion, untrammelled by public law duties such as consultation and freedom of information requirements.

5.3: This discretion could lead to major reconfigurations – shutting whole hospitals is one way to make serious inroads into costs, but with ill effects on accessibility; and would enable radical shifts in the skill-mix employed – the other way of making significant cuts, although a route that undermines the achievement of good outcomes for patients.

6: Health Select Committee's questions

6.1 Joining up health and social care and engaging parts of the system outside the acute healthcare sector,

6.1.2: The rapidity of the timetable for development of STPs and the secrecy required by NHSE has led to very poor buy-in from other organisations in the health and social care arena. There are outstanding issues of funding and accountability which can only be dealt with by the centre and these are getting in the way of effective partnership working. At first, local authorities were not hostile to STPs as they looked forward to receiving support from the ST Fund, but as this money has been sliced away to fund acute sector deficits, it has become clear that additional funding is not available and many local authorities have lost patience, despite what is claimed by NHSE and by health representatives on STPs.

6.1.3: It will not be possible to create effective integration across health and social care unless significant changes are made to means-tested social care provision. We point to the inevitable risk and fear – as is already the case with some conditions, such as dementia, which are clearly illnesses, yet are being funded out of the social care budget or through patients' own pockets after means testing – that this 'reclassification' will spread to other conditions if integration takes place without the creation of a national social care service, as exists in Scotland. 'Integration' will lead to less healthcare free at the point of use and more charges for expanded areas of re-defined social care.

6.1.4: It is notable that most of the claimed involvement by local authorities is by professional officers who are managerial leaders of their service. Often the political leadership is actively against the STP. Chief officer involvement may be motivated by the desire for wider career development at a time when local authorities budgets have been massively cut. It is the political leaders who can claim to be the voice of their community, and the people in that position who are advocating the STPs are few and far between. We suggest that you ask NHSE to differentiate between the two types of role in their evidence to you on the degree and quality of local authority engagement.

6.1.5: We also note that the BMA is advising its GP members not to participate in ACOs while current procurement legislation is in place. They rightly draw attention to the potential for ACOs to lead to privatisation, and warn that this development could hasten the end of a primary care system led by independent GPs. They gave their members a similar warning over the development of multi-specialty community provider (MCP) ACO contracts, and it seems likely that this position influenced large numbers of GPs not to participate in this earlier initiative.⁷

6.2 Reliability of the ratings in the [Sustainability and Transformation Partnerships Progress Dashboard](#),

6.2.1: This dashboard is a fundamentally misconceived tool. It tests compliance by local STPs and CCGs to a centrally determined programme of work and encourages a box-ticking approach by those being tested. It does not look at – nor could such a league table tool look at – the quality of local relationships across the partners, the commitment different partners bring, and their willingness to share the framing and solution of problems. As NHS Providers point out ⁸, footprints vary markedly in the extent to which partnership working existed before the creation of STPs. Those that have a long history of working together will have built up the key factor of mutual trust which is a prerequisite of good partnership working. Local health bodies and local authorities have had statutory powers to work together since the passing of the NHS Act 2006, and some were doing so long before the publication of the Five Year Forward View. Such partnerships can only be assessed by independent evaluation which is able to reflect the diversity of approaches, not by a league table tool.

6.2.2: And for patients, the most meaningful form of integration is when on the ground nurses, social workers, therapists and doctors work closely, out of commitment to good clinical outcomes and in the knowledge that this is what makes the difference. That is what should come ahead of top down imposed organisational integration and that is what has been undermined by competition in the health and social care markets, by underfunding and damaging cuts to social care, and by fragmentation of policy development.

6.3: Deliverability

6.3.1: *(Please see also our comments on the Canterbury, New Zealand ACO experience⁹).*

6.3.2: It is obvious that the NHS and social care lack the resources – including capital investment to fund transformation – to change the boundaries between acute and primary care and, through social care, to use acute care beds more efficiently. The massive funding deficit for both NHS and social care make it entirely unfeasible to go further down the road of stripping out acute beds, which is where most of the desired cuts are due to come from in many STPs.

⁷ Speech by Dr Richard Vautrey, chair of GP Committee of BMA, reported in GP Online Kings Fund

⁸ NHS Providers, Briefing on Accountable Care, 15 January 2018

⁹ Kings Fund, Developing Accountable Care Systems – Lessons from Canterbury, New Zealand, Anna Charles August 2017. https://www.kingsfund.org.uk/sites/default/files/2017-08/Developing_ACSs_final_digital_0.pdf

6.3.3: As the current winter crisis shows, very sick people continue to show up at A&E in large numbers, thus entering the hospital by the front door rather than being referred to community care. In order to cope with this surge in demand, hospitals are creating new acute beds in whatever space they can use rather than cutting more beds. 14,000 beds have been lost since 2010, including approximately 7000 mental health and learning disability beds, which in itself has a huge knock on impact on A&E, where so many patients in mental health distress awaiting admission with or without section, are held for many hours or days awaiting a mental health bed.

6.3.4: There has been an abdication of strategic human resource responsibility since the 2012 Health and Social Care Act. Government did not believe at that time that it had the responsibility to ensure a pipeline of trained staff at all levels, since it believed that market forces would lead to any necessary capacity building. So major policy-driven mistakes were made then – for example, cutting training programmes and NHS student bursaries – which now have their consequences in the recruitment and retention problems which beset the current functioning of the NHS: never mind a future where new capabilities will be needed. We need only look at the record low proportion of fully qualified doctors who are not going on to senior training, the reduced number of future nurses entering training and the fact that more experienced nurses are leaving the NHS in greater numbers, and the catastrophic drop in the number of nurses applying from the European Economic Area for registration with the Nursing and Midwifery Council, to see that the real resources to deliver the service under whatever system are simply not available

6.4: Governance, management and leadership and the British Constitution

6.4.1: Your terms of reference ask about governance issues in relation to STPs, ACSs and ACOs. It seems as though NHSE is proceeding without proper advice from elsewhere in Whitehall about how the British Constitution functions.

6.4.2: A number of judicial reviews are under way, accusing Government and NHS England of acting *ultra vires*, and of failing to fulfil statutory obligations to engage in proper consultation. We do not know whether the courts will uphold these challenges, but we feel bound to draw your attention to the way democratic process is being, in the words of Simon Stevens, 'worked around'

6.4.3: The creation of footprints has forced the CCGs – the statutory bodies with powers and duties to their local population – to join with others to work for the benefit of the population of the whole footprint, and it is clear that this can be to the detriment of the CCG area itself, which in some cases has been required to give up its reserves to bail out other areas with deficits.

6.4.4: Tension has arisen already in at least one case, when Hackney & City CCG refused at first to appoint a common accountable officer, along with the other CCGs in the North East London footprint.¹⁰ After some heavy wielding of the budgetary stick by NHS England, this CCG caved in, but many in the system will be demoralised by evidence that the original vision of local determination, which enticed

¹⁰ Seven CCGs appoint accountable officer, November 2017, <https://www.hsj.co.uk/12084.more>

them into taking up CCG roles in the first place, is being increasingly replaced by central direction, despite the statutory situation.

6.4.5: The speed at which STPs were introduced and the secrecy involved was also an offence against public accountability. Many STPs are now reporting that they are undertaking public engagement on a grand scale, but if that is so, it is not in the areas covered by the many local groups who are affiliates of KONP. Many local authorities have refused to play a part in STPs precisely because the manner of operating offends against standard practice on public consultation in local authorities. Most local authority involvement in STPs consists of work done by senior professional staff rather than the political leaders of the authority, who could be regarded as the legitimate voice of the community.

6.4.6: We are puzzled by the apparent desire by NHSE to push at pace towards ACOs as the desired organisational form for the health and care system, and for two reasons.

6.4.7: Firstly, on openness, the explicit importing of the term 'accountable care organisation' from the USA, coupled with the explicit incorporation into the model contract of the assumption that the private sector will be involved in the competitive tendering process, makes it ludicrous for the Government to claim there is no danger of privatisation.

6.4.8: Secondly, on a point of democracy, since the creation of a new statutory body to take over the powers of the CCGs so obviously needs primary legislation, and current political circumstance make that a difficult path to follow, why is the Government trying to by-pass full parliamentary discussion and scrutiny of this?

6.4.9: We deduce that the current funding famine is leading NHSE to bring the ACO about as the organisational form which will bring acute and community services under one governance roof. Under current rules, most of the NHS asset base (the NHS estate) is mainly held by provider organisations. The funding famine which the health and social care system is currently experiencing sits alongside a relatively generous asset base which the Naylor Review¹¹ proposes should be released to finance the transformation of community services.

6.4.10: Great danger exists in the context of this funding famine, that revenue from one-off fire sales of existing estate will offset provider overspend rather than invest in new health and social care infrastructure. And new estate deemed to be required will be funded from private finance, repeating the expensive mistakes of the past.

6.4.11: However worthy the case for funding expanded community health services from the assets owned by NHS providers, it is fundamentally wrong to do so by showing such contempt for the democratic role of Parliament, seeking to extend executive power and to exercise it through the actions of non-elected officials as in the leadership of NHSE.

¹¹ Independent review by Sir Robert Naylor, March 2017

<https://www.gov.uk/government/publications/nhs-property-and-estates-naylor-review>

6.4.12: We hope that you will take this issue extremely seriously, as nothing could be more important than the role of parliament, as the voice of the public, in agreeing the framework through which public services should operate.

7: Conclusion

7.1: We believe that the NHS – coordinated closely with personal social care brought into the NHS and both funded publicly, as in Scotland, to be provided free at the point of use – is capable of regaining the ground lost over the last 8 years and of enhancing its national and international reputation.

7.2: STPs, ACSs and ACOs have been introduced and developed thoroughly undemocratically.

7.3: Their prime purpose has been explicitly to reduce per capita costs and to impose cost control totals at unprecedentedly low per capita levels, inadequate for meeting the assessed population needs.

7.4: They incorporate a high risk of fragmenting rather than integrating the NHS, into an unspecified number – 44 or 50 or more – of ACOs, with a variety of management organisations and a loss of national standards. The risks are huge yet have not been drawn out or assessed.

7.5: Please put a halt to these dangerous plans lacking in evidence-base, lacking in credibility and lacking in democratic process.

7.6: Thank you for accepting this submission.

7.7: We have written a detailed and well-referenced paper on ACSs and ACOs and this is available at: <https://keepournhspublic.com/wp-content/uploads/2018/01/2017-12-09-KONP-Briefing-Paper-ACOs-ACSs.pdf>

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