Keep Our NHS Public's objections to NHS England's recommendations for changing the law to facilitate Integrated Care Systems

Introduction

In February 2019, NHS England (NHSE) published an Engagement Document, "*Implementing the Long Term Plan*, setting out proposals for possible changes in primary legislation relating to the NHS. NHSE claimed that changes were necessary in order to better allow local NHS and other bodies to work together to redesign care around patients and to remove unnecessary bureaucracy around procurement, pricing and mergers that impede integration of care.

Keep Our NHS Public's (KONP) response, "*NHS England's proposals - 'business as usual*", argued against virtually all of NHSE's proposals, which it said

> "may appear to look towards unpicking the Health & Social Care Act and overriding the structures of the market, but it's clear on closer examination that their proposals head in a very different direction from our aim of reintegrating the NHS."

Rather than seeking to end the market system and competition, NHS England is merely modifying the way it works: even if all its proposals were implemented, all of the elements of the market would remain intact. However, KONP gave conditional support to the proposal abolishing Section 75 of the Health and Social Care Act (HSCA) of 2012, whilst opposing the linked proposal 'giving NHS commissioners more freedom to determine when a procurement process is needed, subject to a new best value test'.

In September 2019, following completion of the engagement exercise and the recommendations of the Health and Social Care Select Committee, NHS England and NHS Improvement (NHSE/I) announced that an NHS Bill would be introduced in the next session of Parliament.

NHSE/I state that a highly targeted Bill would command widespread public support, but that there was little appetite for primary legislation that would trigger further wholesale reorganisation of the NHS.

The proposed Bill, supposedly, would 'rein in' privatisation of the NHS, replacing competition with 'collaboration' and 'integration'. Once enacted, it would "free up different parts of the NHS to work together and with partners more easily", and so speed implementation of NHSE's Long Term Plan, notably the introduction of Integrated Care Systems (ICSs) and Integrated Care Providers (ICPs).

KONP supports the view that partial reform can be a dangerous thing: proposed changes to the HSCA do not end the privatisation of the NHS but push it further.

This document updates KONP's objections to NHSE/I's proposals to take account of their latest recommendations set out in *Integrating Care – The next steps to building strong and effective integrated care systems across England*, which proposes legislative changes similar to those put forward in 2019.

Background: The Health and Social Care Act (2012)

The Health & Social Care Act 2012 (HSCA) is a monstrous piece of legislation, longer than the 1946 Act that set up the NHS, which was forced through parliament by Conservative and LibDem MPs and peers regardless of the near unanimous opposition of doctors, nurses, health professionals and health unions.

Its main provisions were to end the Secretary of State's direct responsibility for providing universal access to a comprehensive range of services; to create NHS England as a free-standing commissioning board; and entrench the division of the NHS into commissioners (over 200 newly created Clinical Commissioning Groups) on the one hand, and providers (NHS trusts, foundation trusts, private companies, charities and non-profit social enterprises) competing for contracts on the other.

This new competitive 'market' was enforced through Section 75 of the Act and its associated regulations. These require CCGs to carve up services into contracts and put them out to tender, fragmenting previously linked services, undermining the financial viability of trusts, and bringing unreliable and unsuitable private providers into the provision of clinical services.

Competition was to be enforced (and any serious collaboration between providers, or between providers and CCGs prevented) by an NHS regulator, Monitor, which has since been incorporated into NHS Improvement, and by, of all things, the Competition and Markets Authority or CMA (formerly the Monopolies and Mergers Commission). The CMA was set up to police and uphold the values of private business but was later brought in to prevent anti-competitive behaviour in the NHS on the assumption that competition was central to maintaining or improving the quality of services.

In the years since the Act was given the Royal Assent its damaging impact and lack of any positive benefit has been increasingly visible for all to see: many of the fears expressed by campaigners such as KONP who fought from the outset to prevent it becoming law have proved accurate.

Irresponsible contracts have been drawn up by clueless and irresponsible CCGs, splitting services away from trusts, and bundling them up for profit-seeking private contractors, many of whom have subsequently gone bust, or walked away when the profits failed to materialise and poor services led to mounting complaints. Long-term deals worth billions have been signed with private providers: more are currently being offered up for tender, even as Health Secretary Matt Hancock pledges no more privatisation on his watch.

For the past seven years since the Five Year Forward View successive plans and projects from NHS England have focused not on competition but on "integration" of services. However it has been clear at each stage that this notion of "integration" has been one that fits within the existing market system of commissioners and providers, and therefore falls well short of any conventional understanding of "integration" into a single coherent whole – which would mean the reinstatement of the NHS as a unified public service.

Indeed the various incarnations of this idea – carving England into 44 areas for 'Sustainability and Transformation Plans' in 2016; proposals for 'Accountable Care Organisations' and 'Accountable Care Systems', swiftly redubbed "Integrated Care Organisations" and "Integrated Care Systems" and more recently "Integrated Care Provider" contracts – all combine an obsessive level of secrecy in their development

with proposals for bodies that would lack either legal legitimacy or even a shred of local accountability to the communities they cover. The latest Long Term Plan as of August 2019 proposed each Integrated Care System would have

> "a partnership board, drawn from and representing commissioners, trusts, primary care networks, and – with the clear expectation that they will wish to participate - local authorities, the voluntary and community sector and other partners".

Such new boards would effectively supplant the existing public bodies. However there is no commitment for them to meet in public, publish their board papers and minutes, be subject to the Freedom of Information Act, or to have any democratic participation from the communities they would cover. Some STPs have already established similar Boards – but they function in secret and have won no public acceptance. Plans for ICSs are being driven through with no consultation, and no transparency.

Worse, the ICSs and their so-called 'partnership boards' would be subject to control by other unaccountable bodies set up by NHS England, Regional Directorates, which are similarly closed to any public scrutiny: they are only accountable upwards to NHS England, not downwards to local people.

We have a clear idea of the type of decisions we could expect from such bodies from the imposition by NHS England of a privatised PET-CT scanning contract on Oxford University Trust despite the opposition from MPs from all parties, the county council and all of the health professionals required to work with the contract. Not only has NHS England ignored the complaints, they have even threatened legal action against the consultants who have pointed out the contract will damage the quality of care provided to cancer patients.

This is far from an exceptional case: the Long Term Plan spells out a commitment to extend new "networks" for imaging services and pathology services which seem certain to lead to further large scale privatisation across the country. Already in South London and the South East the first big pathology network contract, worth £3 billion over 20 years, again developed with no proper engagement with local people o r with NHS staff, has no public sector bid, and others are likely to follow suit.

Nor has any convincing argument been offered to refute fears that larger-scale contracts for Integrated Care Providers could be won by, or substantially subcontracted to private health corporations, or by NHS Trusts in partnership bids with corporate finance bodies.

NHSE's proposals relating to the infrastructure of ICSs are a particular cause for concern, as illustrated by the nature of the Lots on the Health Systems Support Framework and the organisations that have been accredited to provide support for ICS development. The focus of this support is sharply focused on reducing the level and range of services offered and cutting costs rather than arranging comprehensive services to meet patient need.

Although *Integrating Care* includes many references to partnership work with local authorities and responsiveness to local patients and communities, in practice there has been very little real engagement of local authorities and effectively no patient or community involvement in the development of ICSs. This absence of democratic accountability is itself a shocking indictment of the current proposals.

NHS England and NHS Improvement's (NHSE/I) proposals for legislative change

1. Section 75

NHSE/I recommends that Section 75 (s75) of the Health and Social Care Act (2012) dealing with procurement regulations and the competitive tendering of services should be scrapped (Recommendation 4). This would also involve revocation of the Procurement, Patient Choice and Competition Regulations (PCCR). It also calls for Monitor's specific focus and functions in relation to enforcing competition law to be abolished.

KONP's response

KONP initially supported the removal of s75 (one of the most damaging components of the 2012 Act) while recognising that this would do nothing of itself to address the underlying marketising of the NHS. However, as a range of campaigners have pointed out, if turning the NHS into a market is a problem, turning it into an unregulated market is even worse. For example, under the cover of the Covid-19 emergency, we have seen how probity on PPE procurement or Test and Trace contracts has been abandoned and cronyism intensified. KONP is opposed to the competitive tendering of NHS services and the role this plays in the privatisation of the NHS. However, abolishing s75 in the context of an unregulated market will do nothing to safeguard the NHS from further privatisation.

2. The Competition and Markets Authority (CMA)

NHSE/I propose amending the HSCA so that where two NHS foundation trusts or NHS trusts merge (including where one trust is acquired by another), this will not subject to the CMA's merger regime under the Enterprise Act (Recommendation 1)

KONP's response

The CMA is no safeguard of local access or accountability, and certainly no obstacle to privatisation: it serves primarily to regulate behaviour of private companies – supermarkets and bus companies. It argues strongly in favour of competition between NHS providers, including NHS trusts. **KONP believes the CMA has no legitimate role intervening in any element or decisions of the NHS or any public service.** But that's not what NHS England is saying. So we have to ask why NHS England only wants to stop the CMA intervening on one issue.

We believe the answer lies in NHSE/I's emphasis on "managing the NHS's resources better:" The current NHS Long Term Plan states "NHS Improvement will take a more proactive role in supporting collaborative approaches between trusts. We will support trusts that wish to explore formal mergers to embed these benefits". Removing the CMA's ability to intervene suggests that NHS England is seeking **powers to force through mergers.** However much we disagree with the CMA, KONP cannot agree to that objective. We know from painful experience across the country that trust mergers are almost always a prelude to cutbacks and "centralisation" of services that reduce local access.

We also know that mergers always reduce local accountability of trusts, and that they often have negative consequences for NHS staff: we are also against *any* merger being

imposed from the outside and above by NHS England, and anything that makes that easier.

3. **A new procurement regime**

NHSE/I recommend that the commissioning of NHS healthcare services be removed from the scope of the Public Contracts Regulations 2015 (Recommendation 5). These regulations, transposed from a EU directive on public procurement, have meant that all contracts over £615,278 had to go out to tender. NHSE/I suggest that removing the current procurement rules and replacing them with a more flexible new NHS procurement regime will facilitate integration of services by allowing commissioners more discretion when procuring services. Commissioners will be able to choose either to award a contract directly to a provider, or to undertake a procurement process: a full tendering process is unnecessary unless it will be in the interests of patients, taxpayers and the local population.

KONP's response

KONP is not in favour of removing the NHS from the scope of PCRs while contracting remains in place. These regulations allow for equality considerations (such as access for people with disabilities), and social, labour and environmental standards to be built into contracts, along with measures to exclude suppliers with a record of poor performance or who where not adequately equipped for the work. The various PPE contracts dished out without procurement to firms without relevant experience are a scandal that could have been prevented.

Nor is KONP in favour of the proposal to give NHS commissioners more freedom to determine when a procurement process is needed, subject to a new, as yet unspecified, "new NHS procurement regime, supported by statutory guidance" (Recommendation 6). KONP has had little confidence in the judgement of commissioners on whether to put services out to tender. For example, the introduction of CCGs brought dislocation and fragmentation to services. Some CCGs claimed their decisions were forced by the requirements of s75, while others were strongly fully committed to contracting and to privatisation.

4. Patient choice

NHSE/I recommends amending the power to set standing rules in primary legislation to ensure that patient choice rights are protected (Recommendation 7) despite revoking the Procurement, Patient Choice and Competition Regulations (PPCCR). NHSE/I suggest providing powers in primary legislation to set standing rules to ensure that additional provision is made in relation to protecting and promoting the right to patient choice, and then amending the standing rules themselves to include the provisions on choice currently in the PPCCR. This would mean patients continue to have a legal right to choice for particular services and that commissioners are still required to offer choice to patients, including through the use of Any Qualified Provider arrangements and Monitor.

KONP's response

The proposals may have the effect of *strengthening* choice of provider, which KONP sees as one of the ways of increasing private companies' opportunities to provide NHS services.

5. Payments system

NHSE/I recommends that where it specifies a service in the National Tariff, then the national price set for that service may be either a fixed amount or a price described as a formula (Recommendation 8). It further recommends that NHSE/I could amend one or more provisions of the national tariff during the period which it has effect, provided that the change is not sufficiently significant to warrant a consultation exercise (Recommendation 9).

NHSE/I argues that their proposal of specifying a price as a formula has been misunderstood as an abandonment of national prices in favour of locally determined prices. Instead, the aim is to build greater 'flexibility' into the national tariff to allow it to support system change through, for example, a 'blended payment' approach comprised of

- a fixed element (a form of block contract) allowing payments to be based on national prices (e.g. determined by NHHSE/I or Retail Price Index) *and*
- a variable element linked to locally agreed activity plans and that could increase or decrease depending on the extent to which the system reduces its elective backlog.

The model may need to be reviewed in the light of Covid-19. It should be assumed there would be no extra funding from the centre.

KONP's response

We were opposed to the introduction of the "payment by results" system and the tariff that accompanied it in the mid 2000s: we said then that it was part of the marketisation of the NHS, and that the break up of block contracts and service level agreements was part of the process of opening up more NHS services for private providers. But to start to vary the tariff payments while leaving this system intact opens up new possibilities for unequal treatment of one area compared with another, a new 'postcode lottery' that offers no benefits to patients – with all of the changes decided from above by NHS England. As "*Integrating Care*" now makes clear, the fixed payments will be determined locally by each ICS plan, imposed on all trusts in the footprint. (For further discussion, see KONP's detailed response to '*Integrating Care*".)

Flexibility in the tariff could also be used to aid system development by enabling Governing bodies to incentivise or disincentivise particular areas of clinical activity, such as community rather than outpatient follow up. The great worry would be that clinical decisions would be affected by artificial relative costs.

6. New NHS Trusts

NHSE/I recommends that the Secretary of State should continue to have the power to establish NHS trusts (for prescribed purposes) and NHS trusts should continue to be part of the NHS legislative framework (Recommendation 12). It confirms that the primary objective of this proposal is to address a barrier to implementation of Integrated Care Provider (ICP) models.

> "Commissioners may determine, following discussions at Integrated Care System (ICS) level, that an ICP model is right for their population, but there may not exist a suitable and fit for purpose statutory NHS provider to perform the

role of the ICP in that area. The current legislative framework restricts the ability of the NHS to resolve this - a new NHS foundation trust cannot be created from scratch and the 2012 Act did not envisage the creation of any new NHS trusts (it provided for the abolition of NHS trusts, although those provisions have not been brought into force). NHSE/I wanted to retain the current legislation for NHS trusts, repeal the provisions for their abolition and remove any uncertainty about the Secretary of State's power to create a new trust to deliver an ICP contract where local commissioners (with support from ICS members and other local stakeholders) believe that would be the best option. "

KONP's response

These new trusts, like the old trusts and foundation trusts, would remain part of the provider network in the same unreformed market system. Although the proposals are described as supporting integrated care provision, the continued separation of commissioners and providers is not integration, simply a modified disintegration of services. Contracting will continue. The providers will continue to be in competition with each other and with the private sector: indeed the new trusts will be governed by the Integrated Care Provider contract that KONP, Health Campaigns Together and others have campaigned against. KONP have argued that NHS services must be provided directly by public bodies, not through long-term commercial contracts that, over time, may transform NHS bodies into *de facto* commercial companies (albeit not-for-profit).

7. Joint Committees

NHSE/I recommends introducing a provision in legislation to allow both (i) joint committees of CCGs and NHS providers and, (ii) joint committees of providers only (NHS trusts and foundation trusts) (Recommendation 14).

The proposals seek legislative change to enable commissioners and providers of NHS services to come together to make legally binding decisions about their statutory functions, in conjunction with other delivery partners including local authorities, primary care providers and independent and voluntary providers. Systems would be able to use the new power as a basis for establishing ICS Partnership Boards to make decisions about their populations. This change introduces another option for increasing integrated system working which is not possible under the current legislation. The powers would also separately enable closer collaboration between two or more providers.

KONP's response

It is not clear whether each of the organisations within an ICP Partnership Board would retain their individual powers and duties. However, we are concerned that rolling together CCGs that are supposed to commission care for defined local populations breaks any local accountability and winds up with a body that is accountable to nobody – other than upwards to NHS England and its shadowy Regional Directorates. We have seen increasingly far-reaching *de facto*, and now actual, mergers of CCGs, which have effectively disenfranchised local people over large areas of England.

We are also concerned at proposals that Governing Boards of ICSs will include other delivery partners, such as private companies, that will be in a position to shape significant decisions about future local healthcare provision. The accountability of these other partners within joint committees is unclear. It is also unclear how the proposals

on Joint Committees fit with the two Options outlined in 'Integrating Care", of which NHSE/I prefers Option 2, abolishing CCGs entirely.

In place of these proposals, we would wish to see the NHS led and governed at local and regional level through structures led by clinicians, NHS providers and local authorities based on clinical and health priorities and local needs assessment, and with mechanisms to ensure accountability to patients and local communities. KONP supports the Local Government Association's view on integrated care systems that the NHS needs to work in equal partnership with local government in order to address the wider determinants of health, such as affordable housing and a safe environment.

8. Joined up national leadership

This proposal aims to create a single organisation that combines all the relevant functions of NHS England (NHS Commissioning Board) and NHS Improvement (TDA & Monitor) (Recommendation 23). It would establish a single legal entity answerable to the Secretary of State for Health and Social Care and Parliament, responsible for all aspects of NHS performance, finance and care transformation. This would extend NHS England's mandate under section 13A of the 2006 Act to apply to its new provider functions as well as its existing commissioning functions.

KONP's response

This focuses on the wrong issue. The right starting point should be restoring the responsibility of the Secretary of State to provide universal access to comprehensive health services – and establish the accountability of NHS England (which should be brought together with the Arms Length Bodies as an NHS Board) to the Secretary of State.

8. A reserve power to set capital limits on an NHS foundation trust (FTs).

NHSE/I is not proposing a general power to set capital limits on FTs. Instead it is proposing a 'reserve power' to apply to a single named FT, to cease at the end of the current financial year (Recommendation 13). This would, supposedly, provide an ultimate safeguard to the taxpayer should an individual trust's actions threaten to breach national capital expenditure limits. It also pre-empts a situation in which one trust's breach of the capital limit means spending in another community has to be reigned back to ensure the NHS as a whole lives within its allotted capital resources.

KONPs response

This proposal highlights that, despite the rhetoric that powers should be devolved to the most local level possible for effective decision making, the 'centre' will remain firmly in control, with the 42 STP areas increasingly required to collaborate not only within their local system, but to work together as a single "system".

Potentially, an individual Trust Board's responsibility for decisions on capital spending can be undermined while at the same time it will remain accountable for providing safe care. Underfunding of the NHS for many years has meant deficits in the development and maintenance of capital resources across NHS provider organisations, that are now being pushed to self-fund capital projects, for example through selling off NHS land or the use of private finance.

9. A duty to collaborate

NHSE/I recommend that a new statutory Duty is placed on providers and commissioners of NHS services to have regard to the Triple Aim of better care for all patients, better health for everyone, and sustainable use of NHS resources, when considering any aspect of health service provision (Recommendation 17).

This Duty includes a requirement to collaborate with other organisations, not just in considering their local system but also with regard to neighbouring health systems and the wider NHS. It would strengthen the chain of accountability for managing public money within and between NHS organisations.

KONP's response

KONP has always been in favour of an integrated NHS, but sees the current direction of travel following the introduction of STPs, ICSs and ICPs is towards disintegration. In the current context, imposing a statutory duty on organisations to work for the good of the wider system feels like shutting the stable door after the horse has bolted.

As discussed in our detailed response to "Integrated Care", the Triple Aim is intended to mandate "population health management", in which value is to be assigned to the performance of the whole system in each ICS at area level, rather than the delivery of universal, comprehensive care to the individuals who live there. As "*Integrating Care*" states, "Intervention against individual NHS organisations (not working in the best interests of the system) would continue to be enhanced through the new triple aim duty and a new duty to comply with the ICS plan."

Given the proposed statutory duty to collaborate with other organisations, we are particularly concerned to know what is meant by "the sustainable use of NHS and public resources". Resources are defined by NHSE/I as encompassing staff, equipment, estates, expertise and money. This appears to mean that, in the absence of adequate funding, local systems are expected to bail each other out. KONP calls for clarity about how this shared duty would be implemented, especially as it conflicted with an individual organisation's statutory and financial obligations.

In conclusion

KONP opposes almost all of the proposed changes to the Health and Social Care Act on the grounds that these facilitate the continuing privatisation and marketisation of the NHS, albeit in the guise of 'collaboration' and 'integration'. Not least, the changes allow private sector involvement in the governance of ICSs and do nothing to stop future ICPs from extensively sub-contracting to private companies.

Instead, KONP supports proposals set out in the NHS Reinstatement Bill, to repeal the Health & Social Care Act and restore the Secretary of State's duty to provide care and to sweep away the apparatus of the market that divides the NHS. In line with this, we favour the establishment of Health Boards as public, accountable bodies that would plan and provide the full range of NHS services, with participation from elected councillors, community organisations and trade unions. That would be real integration *and* offer substantial savings from costs of contracting and running separate commissioners and providers.

About KONP

Keep Our NHS Public was founded in 2005 to fight the growing drive towards privatisation and marketisation of the NHS under New Labour, and has continued to fight consistently against greatly increased privatisation by Coalition and Conservative Governments since that time, and most recently against the massive wave of private contracts issued without any semblance of competition under Covid-19 emergency legislation

It has campaigned against all forms of privatisation including contracting out by commissioners or by NHS Trusts; PFI; the use of private hospitals to treat NHS-funded patients; Independent Sector Treatment Centres; and measures to force patients towards private treatment by excluding lists of services. KONP has opposed all forms of charges for treatment in the NHS, including the government's imposition of charges on overseas visitors.

We have also campaigned for safe and responsible levels of funding for the NHS, against cuts, mergers, rationalisation and closures that limit local access to care, and helped build strong local campaigns including the recently victorious campaigns to defend Charing Cross and Ealing Hospitals against a massive reconfiguration plan that had recently been scrapped by the government, and other campaigns where local councils have been pressed to refer closures to the Secretary of State.

KONP was at the forefront of the establishment of Health Campaigns Together in the autumn of 2015 as a larger alliance of campaigners with health and other trade unions that has mounted a number of large-scale demonstrations and mobilising conferences.

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