Corporate Agenda for Integrated Care

In late November, NHS England / Improvement (NHSE/I) issued “Integrating care: Next steps to building strong and effective integrated care systems across England”, inviting responses by 8 January.
https://www.england.nhs.uk/wp-content/uploads/2021/01/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems.pdf

Main Proposals

“Integrating Care” signals that the transition from the 2012 Health and Social Care Act to a new framework is expected with primary legislation to be tabled in the Spring. It argues that:

- Clinical Commissioning Groups should be replaced by Integrated Care Systems
- one ICS per footprint (usually the Sustainability and Transformation Partnership (STP) area), including activity in local “places”
- almost all NHS funding should be routed through ICS and
  - be distributed in accord with plans agreed at ICS level
  - using a new payment system.
- It reiterates NHSE/I legislative proposals from Sept 2019 and
- adds two options for the future of CCGs:
  - retain one CCG per footprint and bind all providers and commissioners into joint committees at ICS level, or
  - replace CCGs entirely by ICS (the preferred option).

This may appear to be an innocuous administrative reform of the bureaucracy, to streamline services and deliver better care, but it will move decision-making even further from local communities and increase private sector involvement in the NHS at many levels, including patient records, analysis, financial control and strategic planning and commissioning. Companies poised to take advantage of these reforms include huge corporations, many of them US based. Whilst it is true that the private sector is already heavily involved in the NHS, the proposal would put the entire NHS budget in each footprint under the control of its ICS, and therefore under private sector influence through whatever relationships that ICS may have, including consultancies, infrastructure, and service contracts.

All providers will be bound by a plan written by the ICS Board and financial controls linked to that plan, a new payment system, no veto rights over Board decisions, with private companies able to support the Board and potentially to sit on it, as well as being contracted for services. NHSE/I see this as the opportunity to set the agenda for "how the health and care system might evolve over the next ten years and more.”

Background and Themes

Before looking at the proposals, it is important to understand the background and the themes running through *"Integrating Care"*. These include turning the NHS into a system much closer to the US 'accountable care' model, fundamentally changing the nature of the NHS from a publicly funded and publicly provided service to a system with increased roles for the private sector as clinical services provider, systems consultant and manager, supplier – and potentially, ultimate controller.

A KONP briefing on NHS Integrated Care Systems, the new name for Accountable Care Systems, is here. Historical evidence that ICS are the latest phase of a plan whose long term aim is to convert the NHS to a state health insurance system largely contracted to the private sector is here.

In particular, research by Stewart Player revealed that the essential elements of the Five Year Forward View and the Long Term Plan are drawn directly from two reports issued by the Geneva based World Economic Forum and discussed at its annual Davos conference in 2012. Both reports were co-authored by management consultants McKinsey. The second report, in 2013, includes a "Vision of England's Health System in 2040" in which "The primary locus of care will be the home, powered by technology and remote diagnosis, treatment and monitoring", with citizens "sharing some of the cost of their elective care". "Investments and decisions will be driven by value and data. Our health sector will be known for its transparency on results and value, which will reduce the variability of outcomes. This visibility will generate a competitive and innovative delivery sector."

The current proposals build on the Government response to Covid-19, which NHSE/I portrays as a success whose principles should now be applied to the NHS as a whole. This despite multiple failings to contain the pandemic, culminating in over 150,000 deaths with Covid mentioned on the death certificate and one of the highest per capita Covid death rates in the world and significant detrimental impact on people needing non-Covid care and treatment.

Yet NHSE/I see the UK response to Covid-19 as opening a door. They write: "The COVID-19 pandemic has given the NHS and its partners their biggest challenge of the past 70 years, shining a light on the most successful approaches to protecting health and treating disease… new pathways have rapidly developed across multiple providers that enable and protect capacity for urgent non-COVID care… COVID has made the case for a step up in scope and ambition… The response of the NHS and its partners to COVID-19 and a further year of ICS development has increased the appetite for statutory "clarity" for ICSs and the organisations within them."

Over 3400 Covid contracts totalling £24.4bn have been handed out since March, mainly to the private sector and often without procurement, some involving firms with no relevant experience. Some 70% of the finance came from the Department of Health and Social Care, mainly for PPE and the misnamed "NHS" Test and Trace, overseen by Serco.

"Integrating Care" would open the door to another flood of contracts, once the legislation is in place. Some are already awarded. Eighty three firms, twenty two of them US-based, are accredited by NHSE/I under the Health Systems Support Framework (HSSF) through 10 Lots to support the development of ICS.

In September, NHSE issued a £30m contract notice for “Health Systems Support Framework — Workforce Deployment Solutions”, explaining

> “The NHS is moving towards a more integrated model of care delivery through Integrated Care Systems (ICS). The Health Systems Support Framework (HSSF) was established to provide a mechanism for ICS and other health and social care organisations to access the support and services they need to transform how they deliver care. NHS England and Improvement have determined a requirement to expand the scope of the HSSF in order to provide access to workforce and HR solutions which can help to deliver the NHS Long Term Plan and NHS People Plan. As such we are developing a new workforce service category and, under this procurement, are opening up the HSSF to bids from suppliers of eRostering, job planning and temporary staffing software solutions.”

“Others”

“Integrating Care” never mentions “private”, “independent sector” or “third sector”. The document uses a new codeword, namely ‘others’.

ICS will involve “stronger partnerships in local places between the NHS, local government and *others*...” Since 2018, ICS have been “enabling NHS organisations, local councils, frontline professionals and *others* to join forces”. For ambulance trusts, integration should be “focused on the delivery and redesign with *other* partners of urgent and emergency care pathways”. NHSE/I call for “system-wide governance arrangements (including a system partnership board with NHS, local councils and *other* partners represented)”. The ICS may define “additional membership of each place partnership that is likely to include acute providers, ambulance trusts, the voluntary sector and *other* partners”.

Significantly, the models for future service and provision will be agreed with these unspecified “*others*”. “Provider organisations and *others*, through partnerships at place and in provider collaboratives, become a principal engine of transformation and should agree the future service model and structure of provision jointly through ICS governance (involving transparency and public accountability).”

In the NHSE/I preferred option of a statutory ICS fully replacing CCGs, “the ICS body should be able to appoint such *other* members as it deems appropriate allowing for maximum flexibility for systems to shape their membership to suit the needs of their populations”.

“*Others*” could be anyone, but the 83 firms accredited by NHSE/I under the HSSF are ready and waiting. They include McKinsey (architect of the 2012 Health and Social Care Act), Optum (owned by UnitedHealth, the world’s largest health corporation), IBM, Centene, and other US corporations along with many British and some European companies. Many were awarded Covid contracts in 2020. The table, with US firms in red, shows the number of Covid contracts and their total value, and then the HSSF lots for which each company is accredited, indicating the type of contracts they may obtain to support ICS. The size of each company is shown by its annual turnover.

Company	# of Covid contracts	Covid Value (£)	Lots accredited under HSSF	Annual Turnover
PWC	22	24,623,782	2a,4,6,8,9	US$43.0 bn
Ernst & Young	17	9,133,177	2a,4,5,6,7,8,9,10	US$37.2 bn
McKinsey	16	8,406,350	4,5,6,7,8,9	US$10+ bn
Deloitte	16	22,746,857	2a,3,4,5,6,7,8,9,10	US$47.6 bn
KPMG	12	6,275,780	2a,2b,3,5,6,7,8,9,10	US$29.8 bn
Boston Consulting Group	10	16,422,525	6,8	US$8.5 bn
PA Consulting*	7	14,849,000	2a,2b,3,4,5,6,7,8,9	£500.5 mn
3M	6	16,373,951	4,5	US$32.8 bn
GE Healthcare	6	855,344	2a,2b,4,5,6,8,9	US$19.8 bn
Oliver Wyman	4	438,850	4,5,6,7,8	US$2.1 bn
IBM	2	1,669,748	2a,2b,3,4,5,6,7,8,9,10	US$77.1 bn
IQVIA	2	21,145,837	5	US$11.1 bn
Philips Electronics	2	1,078,977	2b,4,5,7	€19.5 bn
Circle	1	346,600,000	8	£6 mn (2018)
Cerner	1	255,672	1,2a,2b,3,4,5,7	US$ 5.7 bn
Optum	0		2a,4,5,6,7,8,9,10	US$ 100+ bn
Centene	0		2b,3,4,5,6,7,8,9,10	US$74.6 bn

*PA Consulting is now 65% owned by US-based Jacobs, after the Carlyle Group sold its stake

Descriptions of Lots and lists of their accredited suppliers are at https://www.england.nhs.uk/hssf/use-framework/

With a revolving door between government and private sector, it is no surprise that former employees of these companies now hold key positions in the ICS bandwagon. NHSE Chief Executive Simon Stevens was a senior exec at UnitedHealth from 2004 to 2014, and became president of its global health businesses spanning the Americas, Europe, Asia, and Africa. NHSE/I Director of System Improvement Ann Hepworth was previously employed by Optum, and earlier by Optum's parent UnitedHealth. On PM Johnson's secretive NHS Task Force, Adrian Masters was previously Director of Strategy at Monitor, and earlier Director of the Health Team in Blair's "Prime Minister's Delivery Unit". Before that, he worked for PwC, IBM, and McKinsey.

McKinsey was awarded 16 Covid contracts. The Department of Health and Social Care paid McKinsey £563,400 to decide the "vision, purpose and narrative" of the (so-called) NHS Test and Trace programme.

McKinsey is accredited under the HSSF for:

Lot 4 - Informatics, analytics, digital tools to support system planning, assurance and evaluation
Lot 5 - Informatics, analytics, digital tools to support care coordination, risk stratification and decision support
Lot 6 - Transformation and change support
Lot 7 - Patient empowerment and activation
Lot 8 - Demand management and capacity planning support
Lot 9 - System assurance support

McKinsey has been advising governments on how to cut NHS costs ever since their 2009 report commissioned by Gordon Brown in the wake of the financial crisis.

The themes which recur in *"Integrating Care"* correspond with topics for which companies are accredited under the HSSF. Key themes include Population Health, Digital and Data, and Payment Reform.

Population Health

Almost every page of *"Integrating Care"* mentions "population". The introduction highlights the aims of ICS, including:

- Developing strategic commissioning through systems with a focus on population health outcomes

"Integrating Care" does not really explain "population health", but it does state that ICS will "Develop shared cross-system intelligence and analytical functions that use information to improve decision-making at every level, including… the capacity and skills needed for population health management."

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."

Bluntly, this shifts the focus from delivering universal comprehensive care to individuals, to achieving data targets for the population of the area covered by the ICS. Depending on how and by whom and with what aim those data targets are set and on whether the targeted method of delivery corresponds to actual fully staffed resources, what's "good" for the population may or may not be good for the individuals within it.

For example, the ICS may decide to increase treatment at home by 2% per year, and compel all providers to adhere to this plan through the payment system. They may also decide to increase the use of referral management systems, controlling the ability of GPs to refer patients for possible secondary care, using HSSF-accredited companies to run such systems. But how will binding targets to increase treatment at home and referral management affect those patients who may actually need hospital treatment? It will make it harder for them to access it, by targets and systems which may interfere with clinical judgement.

It's entirely appropriate to use healthcare data to predict numbers of procedures. But PHM uses big data to undermine the NHS model of freely provided health care in response to need. It uses big data to specify how much care will be provided, set budgets accordingly and restrict the amount of care by raising the bar (raising the clinical entry criteria) so that specialist NHS facilities can be reduced and patients directed towards the private sector.

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.

One plank of the HSSF framework concerns "Intelligence: targeted population health analytics and digital tools for system modelling, actuarial assessment, planning, research, risk stratification and impactability modelling, and clinical decision support tools".

These topics are covered in Lots 4 and 5, with dozens of accredited companies including

Atos, Centene, Cerner, Deloitte, Ernst & Young, GE Healthcare Finnamore, IBM, IQVIA, McKinsey, Optum, PA Consulting, Philips Electronics, PricewaterhouseCoopers...

But what are these topics? Taking two examples:

“actuarial assessment”

Actuarial science applies statistical methods to assess risk in insurance, finance, and other industries and professions. Actuarial assessment is a technique of bypassing clinical evaluation in favour of statistical analysis to predict risks, whether of developing cancer or committing violent crime. But a 2017 review by the Royal College of Psychiatrists of risks to others in mental health services concluded that "A structured professional judgement approach to assessing risk is preferred to actuarial or unstructured assessments." A BMJ review in 2012 found that "actuarial instruments focusing on historical risk factors perform no better than tools based on clinical judgment". A 2018 paper in the British Journal of Psychiatry evaluated two popular Actuarial Risk Assessment Instruments and concluded "The ARAIs cannot be used to estimate an individual's risk for future violence with any reasonable degree of certainty and should be used with great caution or not at all."

“risk stratification”

Imperial College Health Partners (Risk Stratification for Population Health Management) explain “risk stratification segments the population and attributes cost, enabling the system to identify greatest opportunities for changing the delivery of care”. Risk stratification is a double-edged sword. It is partly a clinical tool which can direct resources where they are most needed, and identify risks before the patient becomes ill. But it is also an essential tool for the health insurance industry, which sets premiums according to the estimated risk that a patient will incur healthcare costs covered by the policy. Milliman is an international actuarial and consulting firm based in Seattle, Washington. Their risk stratification tool MARA is promoted as “a platform-independent software product that fuels population health analytics and helps customers implement financial decisions, payment arrangements, and care support programs with confidence”.

The detailed description of HSSF Lot 5 starts with risk stratification and impactability modelling, and includes the telling phrase “financial impact assessment (to calculate the return on investment)”. Those words make sense to an insurance firm or profit-making healthcare company. But the NHS is not seeking a "return on investment". It is, or should be, focused on the clinical consequences of options.

Listen to some of the US firms accredited for Lot 5, discussing risk stratification, reducing cost of care, especially of ‘high cost’ patients, and insurance plans as they operate in the US:

> **PA Consulting** (now owned by Jacobs): “In a recent analysis for a major provider, we found the need to achieve a 10-fold reduction in cost of care to meet the expected price. Such reductions are only possible by revisiting the care model assumptions and leveraging technology solutions, such as highly precise risk stratification, remote monitoring and telehealth.”
>
> Developing population health programs that add value
>
> **Health Catalyst** (trumpeted as “provider of data and analytics technology and

> services to healthcare organisations, committed to being the catalyst for massive, measurable, data informed health care improvement"): "As value-based care delivery models — like accountable care organizations (ACOs) — enter the healthcare mainstream, managing population health and risk stratification is more important than ever. Healthcare organizations working to change their cost structure and improve outcomes must design interventions that target high-risk, high-cost patients who need to be carefully and proactively managed."
>
> Understanding Risk Stratification, Comorbidities, and the Future of Healthcare

> **IBM** (in suggesting that computer algorithms offer the best way to measure and compensate for the risk of patients attributed to each provider): "Multiple versions of the HHS [US Dept of Health and Human Services] algorithm exist for the metal tiers of available insurance plans: platinum, gold, silver, bronze, and catastrophic. The algorithm will be used as the risk adjustment engine for computing net-zero payment transfers between health plans, based upon average risk of patients in each plan."
>
> IBM: Risk estimation, stratification,and adjustment

Even before legislation is tabled, let alone adopted into UK law, contracts involving population health management are already being announced:

- Healthcare Clinical Information Systems (£1.25bn framework contract with NHS Shared Business Services) in which "Population health solutions are also being considered for inclusion."
- a "Risk Stratification Tool" to cover patient level risk stratification and population level risk profiling

Digital and Data

Another aim highlighted in the introduction to *"Integrating Care"* is:

- The use of digital and data to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care.

ICS will be required to "Have a system-wide digital transformation plan. This should outline the three year journey to digitally-driven, citizen-centred care, and the benefits that digital and data will realise for the system and its citizens."

There are multiple contentious strands in the theme of digital transformation, including four of particular significance for patients: (i) increasing expectation that patients will 'manage their own care' through following on-line guidance; (ii) increased use of algorithms in clinical practice, with the implication that this can substitute for professional expertise, allowing expensive clinicians to be replaced by much cheaper staff; (iii) implications for patient confidentiality as data is shared widely across many organisations; and (iv) potential for sale and sharing of highly valuable patient data with commercial organisations.

Clinical standardisation restricts clinicians autonomy, for example through patient referral

management systems, already widely in use, in which software-guided managers, rather than GPs, control which primary care patients can be referred to secondary care.

We think most people want to see a GP, nurse or therapist in person, and do not want an algorithm to replace a clinical consultation. Some people can manage their own long-term conditions using telemedicine, but others cannot. Some do not have internet access or even a computer. Even for those comfortable with the technology, picking up non-verbal clues and the development of trust during a consultation is much harder in cyberspace. Staff relying on algorithms may lose the opportunity to develop clinical judgement as their own expertise is downgraded. The only passing reference to these issues is one parenthetical mention of “non-digital alternatives”. Instead, the section entitled “Put the citizen at the centre of their care” enthuses:

- Develop a road map for citizen-centred digital channels and services, including access to personalised advice on staying well, access to their own data, and triage to appropriate health and care services.
- Roll out remote monitoring to allow citizens to stay safe at home for longer, using digital tools to help them manage long-term conditions.

Moving from a labour-intensive NHS to digital care inevitably means more private sector involvement, as the digital infrastructure is capital-intensive and privately provided.

ICS will be required 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 [Electronic Patient Records]

The HSSF envisages opportunities for contracts covering all of these issues. For example

Lot 1 (Enterprise-wide Electronic Patient Records systems): “electronic patient record software that enables the secure electronic storage and interrogation of consistent patient data” … “Data export in formats appropriate for integration into other systems, registers and data sets”… Accredited suppliers include US firms Allscripts, Cerner, and DXC Technology.

Lot 2A (Local Health and Care Record solutions (strategy / implementation support)): “services and systems that would have a direct link to the implementation support structure including but not limited to third party suppliers, NHS care providers, private care organisations, local and national infrastructure” … Accredited suppliers include US firms Cerner, GE Healthcare Finnamore, IBM, InterSystems, Optum, PA Consulting.

Lot 2B (Local Health and Care Record solutions (infrastructure)): “appropriate read/write access to patient data by actors across a local economy”... “A Local Health and Care Record will consist of a set of technical capabilities with the precise makeup being determined by each ICS / STP in line with national strategy.” Accredited suppliers include US firms Allscripts, Centene, Cerner, DXC Technology, GE Healthcare Finnamore, IBM, InterSystems, PA Consulting.

Lot 7 (Patient empowerment and activation): “self-care programmes (including social prescribing and innovative technologies and associated wrap around support), and personal health budgets & integrated personal commissioning through sharing information

with care providers remotely" … "Telehealth- remote monitoring of patients in their own homes to anticipate exacerbations early... Telecare- technologies in the citizen's home and communities to minimise risk and provide urgent notification of adverse events; Telemedicine / Teleconsultations- remote peer-to-peer support between clinicians and/or consultations between patients and clinicians." Accredited suppliers include the Dutch electronics giant Philips Electronics, and US firms Centene, Cerner, DXC Technology, Health Management, IBM, Insight Direct, McKinsey, Oliver Wyman, Optum, PA Consulting, Public Consulting Group, and Trustees of Dartmouth College.

Lot 8 (Demand management and capacity planning): "providing a centralised referral management hub that processes all referrals into, through, out of and between care settings. All referrals will be assessed against a standardised set of clinical guidelines and triaged to the most appropriate care provider / pathway". Accredited suppliers include McKinsey, Optum, IBM, PwC, KPMG, Deloitte, Ernst & Young, Circle, and many others

"Integrating Care" also promotes Data Sharing:

> We want to build on the experience of data sharing during COVID so that data is shared, wherever it can and should be. This will inform the upcoming Department of Health and Social Care Data Strategy. While this will be mainly about embedding a culture of sharing data with appropriate safeguards, we would support legislative change that clarifies that sharing data for the benefit of the whole health and care system is a key duty and responsibility of all health and adult social care organisations. This will require a more flexible legislative framework than currently exists to support further evolution and empower local systems to lead and drive that agenda.

Anyone who has tried to get treatment for an existing condition when they are away from home might welcome 'data sharing' from one GP to another or to a hospital. But "sharing data for the benefit of the whole health and care system" is very controversial, not least because the first two Caldicott principles, covering all NHS staff, state clearly:

Justify the purpose(s)
Every proposed use or transfer of personal confidential data within or from an organisation should be clearly defined, scrutinised and documented, with continuing uses regularly reviewed, by an appropriate guardian.

Don't use personal confidential data unless it is absolutely necessary
Personal confidential data items should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose(s).

Data sharing plans uncovered by openDemocracy and tech justice firm Foxglove raised concerns that "NHS users could be re-identified from their health data, that the firms could profit from the intellectual property generated from the project (despite assurances to the contrary), and that contracts pave the way for unprecedented, long-term access to the NHS by unaccountable private firms."

Furthermore, "a parallel system is being built with the help of Faculty and Palantir, overseen by a new body: NHSX. Its head, Matthew Gould, formerly of the Foreign Office, has said that the project isn't just about managing COVID-19, but about reshaping the NHS afterwards."

Increasingly, free trade agreements include chapters on digital services requiring the cross-border flow and storage of data, with the giant multinational companies eyeing up the huge data stores held by the NHS.

Such data stores could also be the target of sophisticated hacking.

In any case, when it comes to *"Integrating Care"*, who decides what is "for benefit of the whole health and care system", and who profits from that decision?

Payment Reform

"Integrating Care" advocates a reform of the payment system, to promote new models of care.

> "we will increasingly organise the finances of the NHS at ICS level and put allocative decisions in the hands of local leaders. We are clear that we want ICSs to be key bodies for financial accountability and financial governance arrangements will need to reflect that… That means that we will create a 'single pot,' which brings together current CCG commissioning budgets, primary care budgets, the majority of specialised commissioning spend, the budgets for certain other directly commissioned services, central support or sustainability funding and nationally-held transformation funding that is allocated to systems. ICS leaders, working with provider collaboratives, must have the freedom – and indeed the duty – to distribute those resources… We will deliver on the commitment set out in the Long Term Plan to mostly move away from episodic or activity-based payment, rolling out the blended payment model for secondary care services."

The blended payment model is not explained in *"Integrating Care"*, but an engagement was announced with a deadline of 10 December 2020. The aim of the payment reform is to shift away from activity-related payments, towards population-based funding. As described in an NHSE/I workshop document published by the Health Service Journal in November, the objective is "a population-based payment and contracting system" in which payment flows create "value", defined as the ratio of Outcomes, relative to population / patient need, divided by Resources (cost). In plain English, this means the system should aim to address the needs of the whole population, and spend as little as possible in doing so.

As discussed earlier, population Outcomes and therefore "Value", depend on how and by whom and with what aim the population data targets are set. Converting to a "Value" based payment system is a priority for companies like McKinsey, who write [https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/the-math-of-acos] "Broad consensus has long existed among public- and private-sector leaders in US healthcare that improvements in healthcare affordability will require, among other changes, a shift away from fee-for-service (FFS) payments to alternative payment models that reward quality and efficiency. The alternative payment model that has gained broadest adoption over the past ten years is the accountable care organization (ACO), in which physicians and/or hospitals assume responsibility for the total cost of care for a population of patients."

As set out in the engagement document Developing the payment system for 2021/22, the model envisages:

> • a fixed payment based on the costs of delivering a level of activity conforming to the ICS system plan
>
> It would cover almost all secondary healthcare services, including acute, community, mental health and ambulance above a contract value threshold.
>
> • the majority of activity will be funded through locally agreed fixed payments rather than national prices.
>
> • Activity undertaken using the elective framework agreement (anticipated to include some independent sector activity) would be outside the scope of blended payments and would be reimbursed on the basis of published prices.
>
> • The value of the fixed payment would be determined locally but, for NHS providers, the starting point for discussion between providers and commissioners is likely to be the payment arrangements in place for the last six months of 2020/21.
>
> • Alongside the blended payment arrangements, providers and commissioners would need to sign up to a System Collaboration and Financial Management Agreement (SCFMA), to share financial risk across the system.
>
> • Each ICS will be expected to agree and codify how financial risk will be managed across places and between provider collaboratives.

Taken together with *"Integrating Care"*, this makes clear that **the ICS will hold the "single pot", and 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.

The intended financial relationship between an ICS and the local authorities in its footprint is unclear. *"Integrated Care"* states:

> Finally, we will further embed reforms to the capital regime introduced in 2019/20 and 2020/21, bringing together at ICS level responsibility for allocating capital envelopes with responsibility for allocating the revenue budgets which fund day-to-day services. This will ensure that capital investment strategies:
>
> • are not only coordinated between different NHS providers, but also aligned with local authorities' management of their estates and wider assets

This suggests financial decisions about local authority estates and assets may be subject to "ICS level responsibility for allocating capital envelopes". The coy phrasing obscures the vast implications of these proposals: that local authority estates and capital assets should be under the control of the ICS.

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. Meanwhile, as quoted earlier, NHSE has issued a £30m contract for "Workforce Deployment Solutions… opening up the HSSF to bids from suppliers of eRostering, job planning and temporary staffing software solutions."

Reform of the payment system is a long-standing demand of healthcare corporations, included in the 2012 World Economic Forum reports which inspired the Five Year Forward View, and the ensuing Long-Term Plan. As Stewart Player commented on the first WEF report:

> Sustainability therefore must be achieved through transforming supply: the various levers with which to accomplish this could include payment innovations related to value rather than volume, with financial incentives aligned to secure good performance for both health and social care; boosting clinicians' productivity through greater use of digital technology; and an emphasis on preventive care, and on more integrated care pathways.

The Health Systems Support Framework also includes reform of the payment system. In Lot 6 (Transformation and Change Support), a section headed "Specialist advice on organisational redesign, governance and payment and contract reform" includes "design of payment mechanisms and incentives across organisations within a local health economy for example allocation of a shared capitated ICS budget / pooled STP budget, or development of risk share methodologies and incentive programmes; utilisation of value and outcome based contracting, where appropriate, to drive and change culture across the ICS / STP" … "outcome based payment mechanisms and models for assessing causality and attribution". Companies accredited under Lot 6 include Deloitte, Ernst & Young, KPMG, PwC, and US firms Centene, DXC Technology, FTI Consulting, GE Healthcare Finnamore, IBM, McKinsey, Oliver Wyman, Optum, PA Consulting, Public Consulting Group, and Boston Consulting Group.

Lot 7 (Patient empowerment and activation) includes "System redesign to enable an ICS / STP to effectively design its services to enable the use of Personal Health Budgets and Integrated Personal Budgets including but not limited to: advice on how to combine resources from across the health and care system to empower people to achieve their health and wellbeing outcomes" … "proactive case finding in which people are identified (using appropriate risk stratification and impactability methodologies)" … "finance platforms to enable effective management of Personal Health Budgets and facilitate required transactions; marketplace platforms that enable individuals to identify and purchase care and support in line with their care plans." … "options for managing the money (with access to direct payment support services and third party budgets); a joined-up process for IPC personal budget implementation and review and an individual statement of resources for the people who can have an IPC personal budget which provides an indicative budget; managing risk in relation to personal budgets and integrated personal budgets i.e. Clinical, Financial, Reputational..."

NHSE/I Proposals

With all of the above in mind, what is *"Integrating Care"* actually proposing? First, NHSE/I reiterates the legislative proposals they issued in September 2019.

[*see separate article on legislative proposals*]

The proposals include the creation of Integrated Care Providers (ICPs), although only statutory NHS providers should be permitted to hold NHS ICP contracts. However, as KONP argued, “NHS services must be provided directly by public bodies, not through long-term commercial contracts which, over time, may transform NHS bodies into de facto commercial companies (albeit not-for-profit).”

To enable the creation of ICPs, NHSE/I would “remove the commissioning of NHS healthcare services from the jurisdiction of the Public Contracts Regulations 2015”, which also means removing what little safeguards there are over compliance with ILO Conventions (fundamental worker rights), equalities, social, and environmental impact, as well as contractors previous poor performance, and whether they are adequately equipped to do the job (unlike some of the companies handed Covid contracts in 2020).

Appendix 1 lists reports of some recent scandals involving companies accredited under the HSSF.

Another proposal includes “the ability to set a ‘blended tariff’ using a national formula, rather than only being able to set a fixed national price”, intended to give a legal basis for the blended payments model on which NHSE/I has already consulted.

The proposals introduce a new “Triple Aim” for NHS commissioners and providers, of “better health for the whole population, better quality care for all patients and financially sustainable services for the taxpayer”. The first of these makes population health a required goal.

The 2019 proposals were cautious on organisational form. At point 10, they stated:

> The Select Committee agreed that NHS commissioners and providers should be newly allowed to form joint decision-making committees on a voluntary basis, rather than the alternative of creating Integrated Care Systems (ICS) as new statutory bodies, which would necessitate a major NHS reorganisation. We propose that NHS England and NHS Improvement should not have any new and additional powers of intervention in relation to such committees beyond those that exist in relation to CCGs and NHS providers.

However, this stance is abandoned in the second part of the legislative proposals in *“Integrating Care”.* NHSE/I now outline two options.

Option 1

a statutory ICS Board / Joint Committee with an Accountable Officer

This would “establish a mandatory, rather than voluntary, statutory ICS Board through the mechanism of a joint committee and enable NHS commissioners, providers and local authorities to take decisions collectively” … “it would have a system Accountable Officer, chosen from the CEOs/AOs of the Board’s mandatory members” … “There would be a duty for the Board to agree and deliver a system plan and all members would have an explicit duty to comply with it” … “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.”

This Option places overall control in the hands of the ICS Board joint committee, with an Accountable Officer, and would compel individual organisations to comply with the system

plan and penalise them for not “working in the best interests of the system”. But NHSE/I prefers an even stronger variant.

Option 2

a statutory ICS body

“The CCG governing body and GP membership model would be replaced by a board consisting of representatives from the system partners. As a minimum it would include representatives of NHS providers, primary care and local government alongside a Chair, a Chief Executive and a Chief Financial Officer. The ICS body should be able to appoint such other members as it deems appropriate allowing for maximum flexibility for systems to shape their membership to suit the needs of their populations. The power of individual organisational veto would be removed. The ICS Chief Executive would be a full-time Accounting Officer role… The ICS’s primary duty would be to secure the effective provision of health services to meet the needs of the system population, working in collaboration with partner organisations.”

Naturally, “other members” appointed to the ICS board could be experts in population health management, risk stratification or blended payments, and “partner organisations” could be any of those accredited under the HSSF.

This possibility is so crucial that in the current consultation NHSE/I invite respondents to agree that "membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs".

Why does NHSE/I prefer Option 2, given that “both models would drive increased system collaboration and achieve our vision and our aims for ICSs in the immediate term”?

“… [Option 2] offers greater long term clarity in terms of system leadership and accountability. It also provides a clearer statutory vehicle for deepening integration across health and local government over time. It also provides enhanced flexibility for systems to decide who and how best to deliver services by both taking on additional commissioning functions from NHS England but also deciding with system colleagues (providers and local councils) where and how best service provision should take place.”

Furthermore, [Option 1] “may not be the “end state” for ICSs and opportunities for primary legislative change are relatively rare. There are therefore strong arguments to go further when considering how the health and care system might evolve over the next ten years and more.”

NHSE/I sees this as the moment for a final throw of the dice, to convert the NHS to a system based on “integrated care” with one decision-making body per ICS footprint, funding redesigned to promote system-wide plans which NHS bodies will be compelled to follow, and 83 corporations accredited to support the development, potentially join the Board and help to write the ICS plans, and in any case be involved in delivering them. Their eyes are focused on the money. The public, currently entitled to attend and question local CCGs, will be nowhere in sight when key decisions are taken.

Appendix 1: some recent scandals involving firms accredited by the HSSF

PwC:
https://www.theguardian.com/world/2020/jan/23/pwc-growing-scrutiny-isabel-dos-santos-scandal-luanda-leaks-angola
https://www.bbc.co.uk/news/business-48621095
https://www.insurancejournal.com/news/international/2020/07/02/574138.htm
https://corpwatch.org/article/bcg-mckinsey-pwc-consultants-implicated-angola-corruption-scandal

Ernst & Young
https://www.wsj.com/articles/ernst-young-loses-two-german-clients-amid-wirecard-scandal-11599072589
https://www.insurancejournal.com/news/international/2020/07/02/574138.htm
https://www.dailymaverick.co.za/article/2020-08-26-audit-firm-ey-incompetent-negligent-or-criminal/

McKinsey
https://www.nytimes.com/2019/12/14/sunday-review/mckinsey-ice-buttigieg.html
https://www.dailymaverick.co.za/article/2020-04-29-mckinsey-profit-over-principle/
https://corpwatch.org/article/bcg-mckinsey-pwc-consultants-implicated-angola-corruption-scandal

Deloitte
https://www.theguardian.com/business/2020/sep/17/deloitte-fined-record-15m-for-failings-in-autonomy-audits
https://www.dailymaverick.co.za/article/2020-08-12-deloot-how-deloitte-gets-away-with-it/

KPMG
https://www.dailymaverick.co.za/article/2020-09-22-kpmg-rogue-reports-dead-cows-and-state-capture/
https://edition.cnn.com/2020/07/06/business/uk-big-4-accountancy-firms-frc/index.html
https://www.marketwatch.com/story/the-kpmg-cheating-scandal-was-much-more-widespread-than-originally-thought-2019-06-18

Boston Consulting Group
https://www.consultancy.uk/news/25610/government-moonshot-programme-will-cost-uk-over-100-billion
https://corpwatch.org/article/bcg-mckinsey-pwc-consultants-implicated-angola-corruption-scandal

IBM
https://www.propublica.org/article/ibm-accused-of-not-disclosing-ages-people-40-and-older-laid-off
https://features.propublica.org/ibm/ibm-age-discrimination-american-workers/

Centene
https://www.nytimes.com/2018/01/11/health/centene-health-insurance-lawsuit.html

Optum
https://www.healthcarefinancenews.com/news/study-finds-racial-bias-optum-algorithm
https://www.vice.com/en/article/3dpvx5/david-camerons-former-health-advisor-joined-an-

nhs-privatisation-firm

Optum has come unstuck with “healthy living” projects in the South West. In 2015, on behalf of Public Health Dorset, the County Council appointed Optum to provide the **Dorset Health Improvement Hub**. “LiveWell Dorset, will act as a single point of contact that will help people with their health and wellbeing including advising people about their smoking, drinking, weight, diet and exercise, and assisting them to adopt a healthier lifestyle, potentially reducing the risk of developing more serious health issues later in life.”

By 2017, the Council began regular meetings with staff “to provide a forum to address concerns, and keep staff briefed as to the future intentions with the service.” In April 2018 it was brought in-house to be run by the Public Health team.

Over in Devon the Council’s "healthy lifestyle" service was outsourced to Optum, who then refused to transfer existing employees. Unison accused the firm of jeopardising £1m of taxpayer’s money, by reneging on the agreement.

Despite these experiences, the NHSE/I operating model for *“Integrating Care”* intends much support “will be made available to systems through **regional improvement hubs**, which will ensure that improvement resource supports local capacity-and capability-building. Systems will then able to flexibly and rapidly deploy the support into place partnerships and provider collaboratives.”