Integrated Care Systems
+
White Paper Feb 2021
and
Legislation imminent June 2021

June 2021

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This presentation has been developed by the KONP Working Group on ICSs and the White Paper. It will give a brief run through of the background to Integrated Care Systems (ICSs) and the White Paper of February 2021, and the legislation which is expected any day now following announcement in Queen's Speech. A majority of areas already claim to be ICSs but the finance systems they are using and the lack of statutory support for joint decision making mean they are not really ICSs yet. The legislation will fix that!

There isn't time for a lot of discussion or questions on the background – it's intended to remind you what you already know and to set ICSs in context. The whole session will take about 45 mins, and then there'll be time for questions and discussion. But please can you keep questions and comments about the content of the presentation to a minimum – email me afterwards if you want to discuss something – and this whole presentation will be on the KONP website, so you can get all the detail and references there. In the discussion I'd really like to concentrate on what you're already doing to campaign and any plans, including using the campaign materials KONP has developed.

Words do not mean what we think they mean – like integrated / integration. Integrated Care Systems is a dishonest label – it's not about collaborating to improve patient care; it is about financial systems to cut costs and enable profit sharing and further embed the private sector in running the NHS (and social care). Deborah Harrington speech in Liverpool, https://youtu.be/dpYzcdyXUOk It is about integrating organisations, not services. We must not forget that many services do already work well together across organisational boundaries, and staff work really hard to reduce barriers.

There is little evidence that 'integration' does what the government wants it to do:

That closer working between organisations reduces costs particularly of emergency admissions to hospital: https://www.health.org.uk/publications/impact-integrated-care-teams-hospital-use-north-east-hampshire-and-farnham ; and https://www.sciencedirect.com/science/article/pii/S0277953620307310

That more 'integrated care' leads to better disease prevention: https://ihj.bmj.com/content/2/1/e000013 (2019/20)

That integration leads to better outcomes for patients: National Audit Office 'Health and Social Care Integration' HC 1011 Session 2016-17, 8 February 2017 https://www.nao.org.uk/report/health-and-social-care-integration/

Research in the USA and experience in England has exposed the lack of evidence that data-led attempts at "population health management," or targeting the small number of patients with complex medical and social needs, can either reduce demand or cut costs. However, such approaches do facilitate the development of private insurance pathways running alongside NHS care.
England ref: HSJ 19 Nov 2014 – integration won't save money

Thatcher's and Major's governments (1979-90, 1990-97) privatised many public services – such as the utilities – but it was only really non-clinical services in the NHS (catering, cleaning, laundry, portering, security etc) which were privatised, not NHS clinical services. Despite vigorous campaigning, the Conservatives introduced the 'internal market' with the **purchaser/provider split** and set up NHS Trusts which could 'opt out' of local NHS health authority control.

Under the 1997-2010 Labour government, things speeded up – from the semi-autonomous Foundation Trusts to ICATS the paths were opened for entry by the private sector. Brown commissioned a report from McKinsey, which recommended the sort of moves we've become used to – all about reducing the cost particularly of expensive hospital treatment. And supposedly doing more about preventing ill health – but, of course, if the social determinants of health were really tackled – income and poverty, disadvantage and discrimination facing BAME communities, housing, education – they would not be cheaper; and there has not been extra funding for community health or mental health services.

And then there was the 2012 Act – written for Lansley by McKinsey. We assume most people are familiar with the campaign against this Act. It abolished the Secretary of State's 'duty to provide' a comprehensive national health service; it restructured the NHS – created Clinical Commissioning Groups, abolished Primary Care Trusts; made it compulsory for CCGs to put services out to tender – Section 75 – which led to a massive influx of private sector providers for even quite small contracts; transferred public health to local authorities – and only ringfenced their budgets for a short time.

The WEF is a chance for the big corporates to meet with world leaders. McKinsey got in on the act there too, so you can see they were doing for the world what they'd done for England.

It was about finding more ways to involve the private sector, to use fewer (expensive) staff – for example by digital technology; to ration and/or to increase productivity; to encourage 'self care' (we'll come back to that later).

Simon Stevens is now **Chief Executive of NHS England,** was health policy advisor to Blair, was President of Global Health at UnitedHealth Group

References

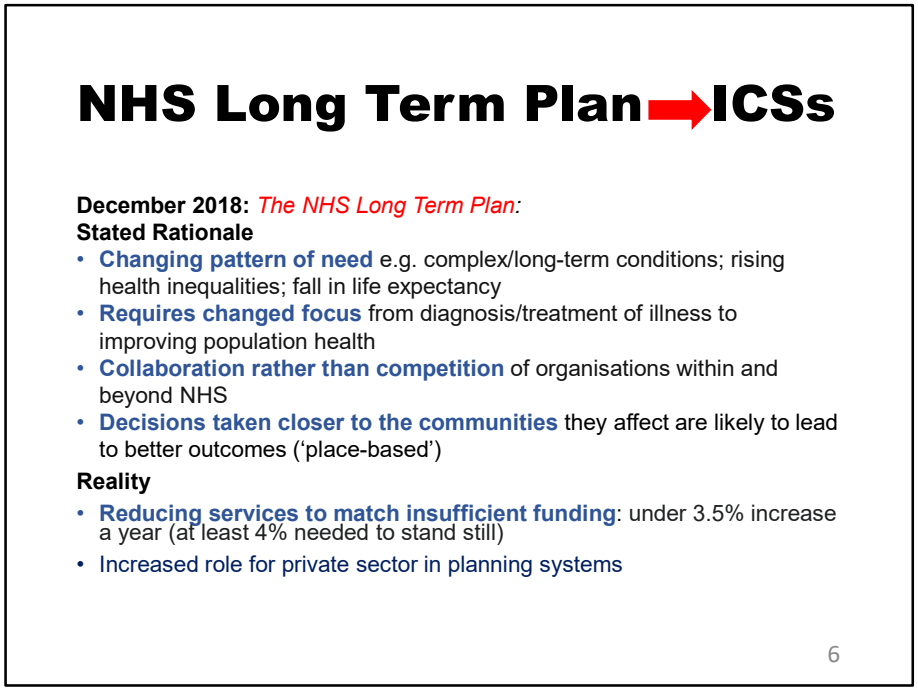
WEF 'The Financial Sustainability of Health Systems: a Case for Change' 2012: http://www3.weforum.org/docs/WEF_HE_SustainabilityHealthSystems_Report_2012.pdf

WEF 'Sustainable Health Systems Visions, Strategies, Critical Uncertainties and Scenarios' 2013: http://www3.weforum.org/docs/WEF_SustainableHealthSystems_Report_2013.pdf

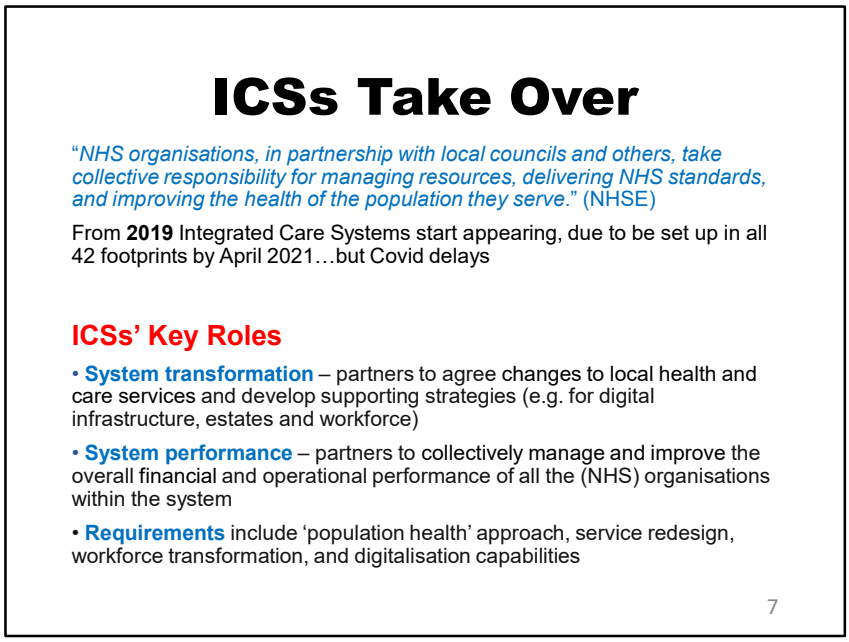
Back to England and the various steps under the Coalition and then Conservative government. This and the next slide show some milestone dates, reports and plans, and new organisations' names and terms: Integrated Care, Sustainability and Transformation Partnerships, accountable care.

Important point: many of the measures introduced by 5YFV and Next Steps mirror recommendations of WEF report.

All this was being done without statutory backing for the changes.



So we get the Long Term Plan, where the stated rationale – much of which is true – is very different from what the underlying purpose is in reality. And which set the immediate context for the move to ICSs (the new, more acceptable name for Accountable Care Organisations, because that was tarnished with accusations of being 'Americanisation')

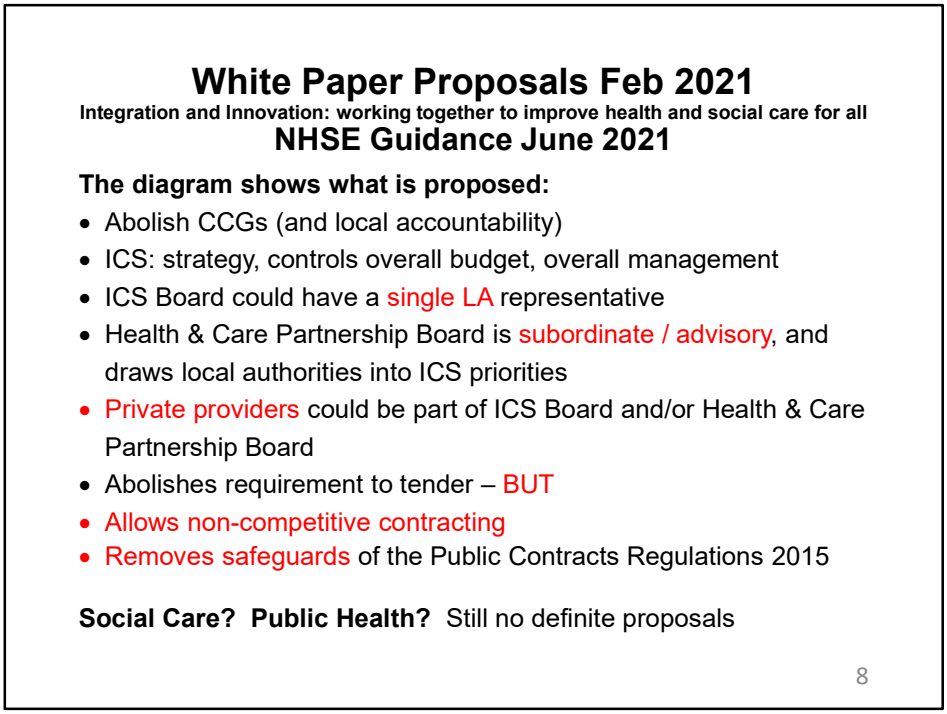


Now we're going to look in more detail at what ICSs are, and how the White Paper proposed transforming the plans into legislation.

NHSE consultation November 2020 to January 2021:
https://www.england.nhs.uk/publication/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems-across-england
and response to the consultation: https://www.england.nhs.uk/publication/legislating-for-integrated-care-systems-five-recommendations-to-government-and-parliament/ which appears to have deliberately ignored over 5000 responses from KONP supporters.

The emphasis is that all the health organisations involved must be bound together by collective responsibility: in agreeing changes to services and how to deliver that; in managing the overall financial and operational performance – so all the health provider organisations involved will be held accountable for delivering both their individual control total and the overall system control total.
2.11. Local flexibility will be important but providers in every system, through partnership or any new collaborative arrangements, must be able to:
• deliver relevant programmes on behalf of all partners in the system;
• agree proposals developed by clinical and operational networks, and implement resulting changes (such as implementing standard operating procedures to support agreed practice; designating services to ensure their sustainability; or wider service reconfiguration);
• challenge and hold each other to account through agreed systems, processes and ways of working, e.g. an open-book approach to finances/planning;
• enact mutual aid arrangements to enhance resilience, for example by collectively managing waiting lists across the system.
2.29 quotes the Long Term Plan: • system-wide governance arrangements (including a system partnership board with NHS, local councils and other partners represented) to enable a collective model of responsibility and decision-making;

The Requirements are about 'new models of care' which are said to be about more preventive care, more locally and community based, about using data and digital to identify high risk groups or individuals and redesigning services to meet their needs – a 'population health approach' - and for staff it's about trying to break down professional 'barriers' and getting lower graded staff to take on wider responsibilities. And it's still mostly about cutting costs and opening up possibilities for private sector.



The White Paper and NHSE Guidance June 2021 proposals in a nutshell.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/960549/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-print-version.pdf
What the White Paper says sounds good: 1.13 "… two forms of integration … within the NHS to **remove some of the cumbersome boundaries to collaboration and to make working together an organising principle; and greater collaboration between the NHS and local government, as well as wider delivery partners, to deliver improved outcomes to health and wellbeing for local people.**
1.14 The NHS and local authorities will be given a duty to collaborate with each other."
1.15 "…Enabling the NHS and local authorities to arrange healthcare services to meet current and future challenges by ensuring that public and taxpayer value – and joined up care – are first and foremost."

NHSE Guidance June 2021, https://www.england.nhs.uk/publication/integrated-care-systems-design-framework/?utm_campaign=411157_PRESS%20STATEMENT%20ICS%20framework%20comment&utm_medium=email&utm_source=NHS%20Confederation&dm_i=6OI9,8T91,2M7P4V,11M9H,1
HSJ articles 16 and 17 June: at least 10 mandatory members for "ICS NHS body" boards. The minimum required board members include:

- Four executives – the chief executive and finance, nursing and medical directors.
- Three independent non-executives: a chair and at least two others. They "will normally not hold positions or offices in other health and care organisations within the ICS footprint".
- Three "partner members": one from an NHS trust/foundation trust in the patch, one from general practice, and **one from a local authority**. They will "not be acting as delegates of those sectors", however.

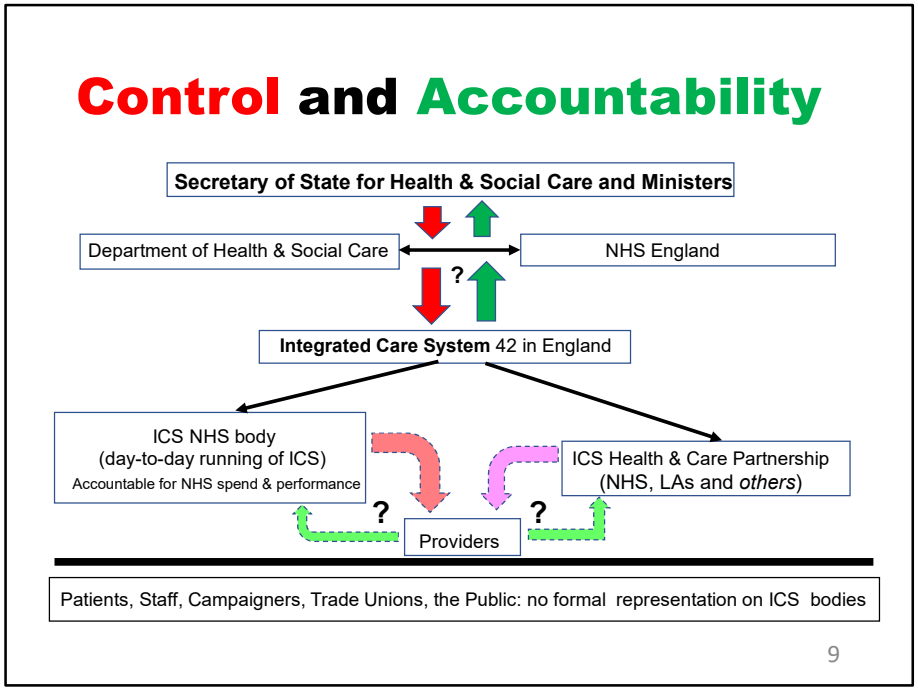
Beyond this the rules are quite flexible. Systems can add more ICS NHS body board members to suit their needs - but these are subject to approval by NHS England and boards should be "an appropriate size to allow effective decision making to take place", according to the design framework.
Rules for ICS Partnership boards will be published separately by government. But guidance indicates they must have a chair jointly selected by the ICS NHS body and local authorities; and said "some systems will prefer the Partnership and ICS NHS body to have separate chairs".
The paper says the partnership will act like a "forum" (committee not corporate body) and operate under consensus agreement decision making.

Further guidance is expected on provider collaboratives in coming months, though the document said ICS could "contract with and pay providers within a collaborative individually" or contract with a lead provider on behalf of a collaborative". it said the ICS NHS board and chief executive "will be ultimately responsible for services under delegation arrangements with place-based partnerships or through lead provider contracts."

But the slide shows what some of this will translate into.
Local authorities won't be controlled by ICSs, but they will be drawn into the system: 5.99 " …guidance that will offer support for how ICS Health and Care Partnerships can be used to align operating practices and culture with the legislative framework to ensure ICSs deliver for the ASC sector." although 6.19: "The Health and Care Partnership will be promoting collaboration and it would not impose arrangements that are binding on either party, given this would cut across existing local authority and NHS accountabilities." And LAs lose powers in relation to reconfiguration of services – covered later.
And the **private sector** is still very much there: 5.49 "We anticipate that there will continue to be an important role for voluntary and independent sector providers" especially with non-competitive contracting and the removal of regulatory safeguards.

Abolishing the requirement to tender but allowing 'non-competitive contracting' – the ICS can choose to award a contract; and removal of the **Public Contracts Regulations:** means removing environmental, social and labour law safeguards (Sub-section 7, 56); 56); and removes their ability to take account of contractors' previous poor performance, and whether they are adequately equipped to do the job. So it becomes an **unregulated market.**

Social Care and Public Health – no real commitment
1.18 "…committed to bringing forward proposals this year [on **social care reform**] … The government will publish in due course an update on proposals for the future design of the **public health system**." Obesity and fluoridation are specific areas mentioned.
Social Care: 5.99 onwards – vague – things they say they 'will' / 'want to' do. EXCEPT: new controls over local authority work: 5.108: a new duty for the Care Quality Commission to assess local authorities' delivery of their adult social care duties, and a new power for the Secretary of State to intervene where, following that assessment, it is considered that a local authority is failing to meet their duties. And 5.110 Secretary of State can make payments directly to social care providers (including those for-profit).



This is what we think the White Paper / NHSE guidance means in terms of the different organisational levels. Claims that this is a 'bottom up approach' – but really means increased centralisation of control.

The red arrows, pointing down, are about control, and the green ones pointing up are about accountability. But although the White Paper mentions 'accountability' many times, it's not really clear who the different levels are accountable, other than perhaps to the Secretary of State. Certainly not to 'the public'.

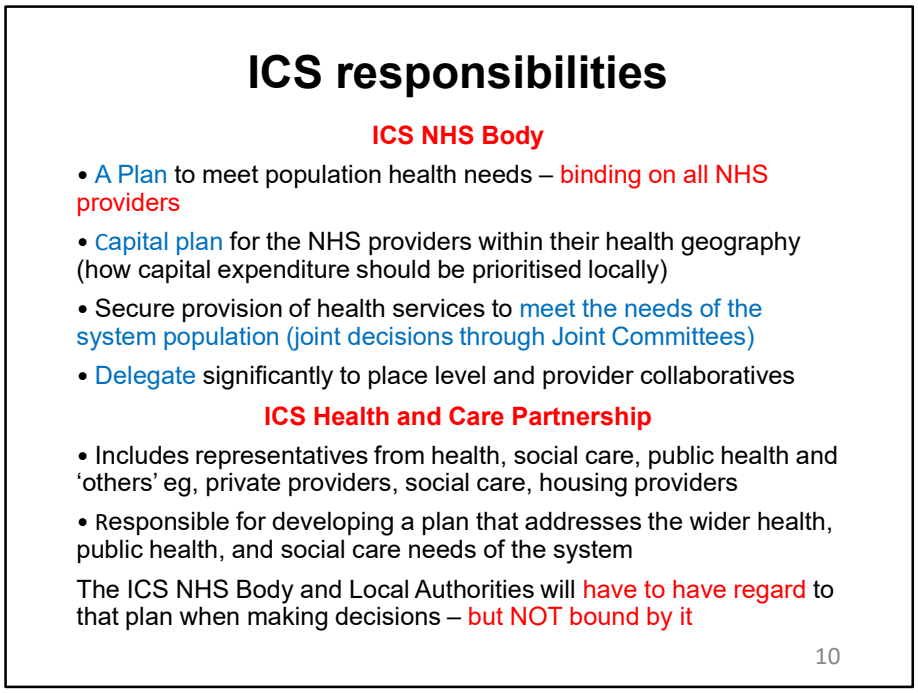
The NHSE consultation referred to just one ICS Board, but the White Paper – because of concerns from the Local Government Association – suggests two. The ICS NHS Body would be responsible for the day to day running of the ICS, and would be required to set up a Health and Care Partnership body, which would clearly be subordinate. Simon Stevens quoted by HSJ referred to the Health and Care Partnership Board as "an advisory partnership": HSJ 15 April 2021; and when asked about an example of reconfiguration where the two levels disagreed, he made it clear that the ICS NHS Body would have a superior overview of the needs of the whole area.

The ICS NHS Body is 'accountable for NHS spend and performance' so presumably will be holding the Providers to account – but 5.12 says: "The ICS NHS Body will not have the power to direct providers, and providers' relationships with the Care Quality Commission will remain unchanged. However, these arrangements will be supplemented by a new duty to compel providers to have regard to the system financial objectives so both providers and ICS NHS Bodies are mutually invested in achieving financial control at system level."

And it's not clear what role the ICS Health and Care Partnership Board has in relation to Providers.

Below the black line, all the groups who apparently don't have any say in control or accountability – as they have no formal representation on ICS bodies. The limited say that those groups have at the moment are largely through local authority bodies, such as Health and Wellbeing Boards, Health Scrutiny Committees, and possibly via Health Watch or through Patient Participation Groups in GPs practices. If the local authority is bound by the ICS plan and financial controls, can it still be a route to question decisions about services? The section in the NHSE guidance on the Partnership Board

says: “Partnerships will need clear and transparent mechanisms for ensuring strategies are developed with people with lived experience of health and care services and communities, for example including patients, service users, unpaid carers and traditionally under-represented groups.” and the section on ‘Working with People and Communities’ talks about: “how to listen consistently to, and collectively act on, the experience and aspirations of local people and communities …supporting people to sustain and improve their health and wellbeing, as well as involving people and communities in developing plans and priorities”, to have a range of engagement activities prioritising groups affected by inequalities. And that this will involve “a legal duty for ICS NHS bodies to make arrangements to involve patients, unpaid carers and the public in planning and commissioning arrangements” and that this should be “a source of genuine co-production and a key tool for supporting accountability and transparency of the system”. We’ll need to make sure we make the most of these opportunities for involvement and holding ICSs to account – if we don’t manage to stop them.



A bit more detail about what the White Paper and the NHSE guidance say about responsibilities of the two different ICS Boards. Section 3 of the White Paper, especially 3.9 onwards, and Section 5 cover the two proposed bodies and their relationship to each other – and how local authorities are involved. 6.18 covers the governance arrangements and what representatives could be on the ICS NHS Board: there could be just one representative for all the LAs within the geographical area; private sector could have seats on the Board.

There is reference in the White Paper to controls on NHS Foundation Trusts capital expenditure, and a system-wide capital limit.

Proposal would allow Joint Committees of ICS and NHS Providers, and also NHS Providers could form their own Joint Committees. Currently this is not legal. Both sorts of Joint Committees could have representation from other bodies such as primary care networks, GP practices, community health providers, local authorities or the voluntary sector. (? And private sector)
NHSE guidance p22: ... The board may establish other decision-making **committees**, in accordance with its **scheme of delegation** ... The legislation is expected to give ICS NHS bodies **flexibility** in how they establish and deploy such committees. In particular, they will have the power to: • **appoint individuals who are not board members or staff of the ICS NHS body to be members of any committee it has established** – could include private sector.

p24: An NHS ICS body could establish any of the following place-based governance arrangements with local authorities and **other partners**, to jointly drive and oversee local integration: ...
• **committee** of the ICS NHS body with **delegated authority to take decisions about the use of ICS NHS body resources**
Private companies could get on committees with delegated authority for use of resources

Overall strategy at ICS NHS Body level – binding all NHS organisations involved to the plan and the system's financial control total; the NHSE guidance says: "bind partner organisations together in a new way with common purpose. They will lead integration within the NHS, bringing together all those involved in planning and providing NHS services to take a collaborative approach to

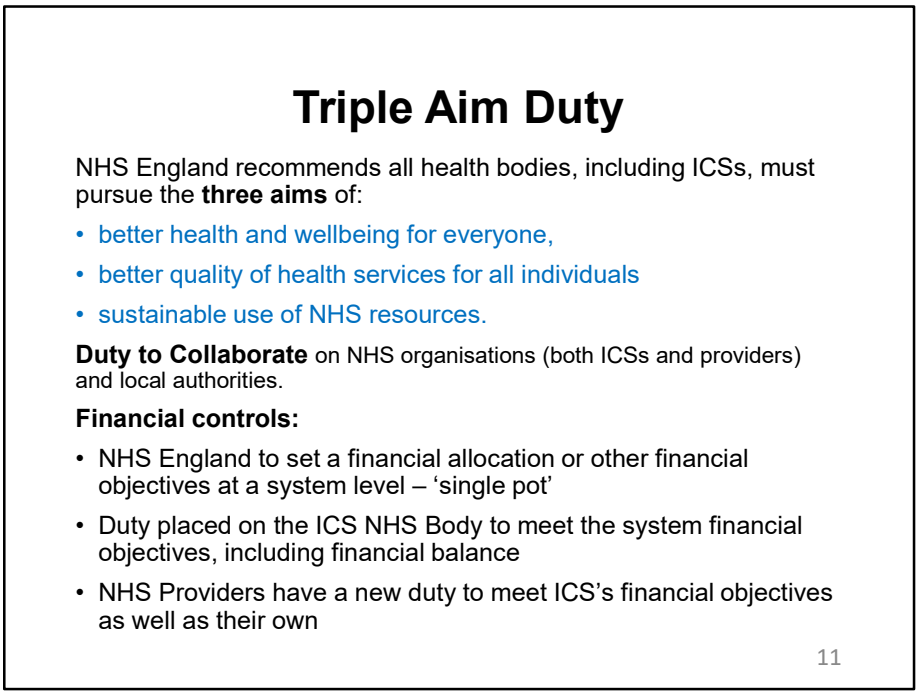
agreeing and delivering ambitions for the health of their population. " and "Arranging for the provision of health services in line with the allocated resources across the ICS".
The ICS Health and Care Partnership will probably be the level where decisions on service design and delivery are taken.

The ICS NHS Body will be able to delegate functions, "which may be managed by place-based partnerships or provider collaboratives"
– that could include private sector?

The ICS NHS Body has the final say in decisions:
White Paper 5.11 "The ICS will also have to work closely with local Health and Wellbeing Boards (HWB) as they have the experience as 'place-based' planners, and the ICS NHS Body will be required to ***have regard*** to the Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies that are being produced at HWB level (and vice-versa)." and the ICS NHS body will have to '***have regard***' to the ICS Health and Care Partnership plan – but not **bound** by it.
What does 'have to have regard to' mean in relation to local authorities' **social care plans**?

In the NHSE guidance, there is more detail about what is expected of the Partnership Body:
"ICS Partnership will have a specific responsibility to develop an 'integrated care strategy' for its whole population using best available evidence and data, covering health and social care (both children's and adult's social care), and addressing the wider determinants of health and wellbeing. This should be built bottom-up from local assessments of needs and assets identified at place level, based on Joint Strategic Needs Assessments. We expect these plans to be focused on improving health and care outcomes, reducing inequalities and addressing the consequences of the pandemic for communities."

Members of the Partnership Body must include local authorities that are responsible for social care services in the ICS area, as well as the local NHS (represented at least by the ICS NHS body). Beyond this, members may be from health and wellbeing boards, other statutory organisations, voluntary, community and social enterprise (VCSE) sector partners, social care providers and organisations with a relevant wider interest, such as employers, housing and education providers and the criminal justice system.



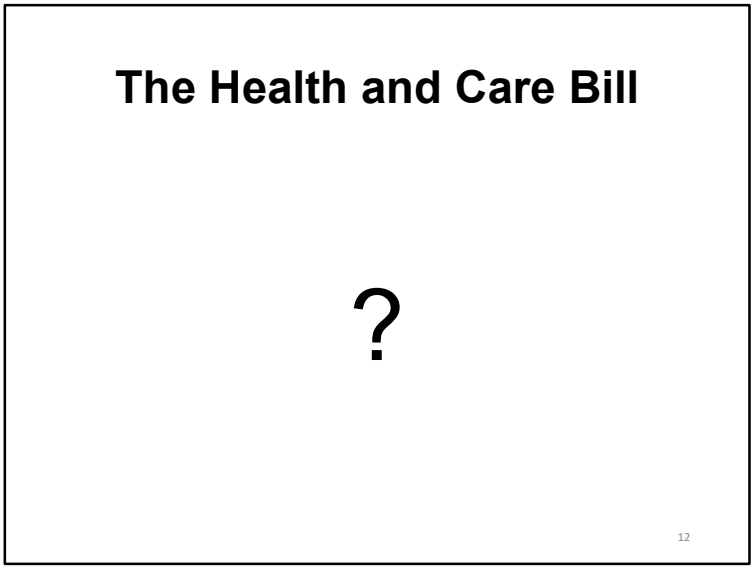
The final slide on the detail of ICSs is about the requirement of the 'Triple Aim Duty' – where 'sustainable use of NHS resources' has equal footing with better health and wellbeing and better quality of health services, and all the health organisations involved are constrained by a 'single pot' budget (that does not include social care – yet).

The new Duty to Collaborate (5.14 and 5.15) does include local authorities, to promote collaboration "across the healthcare, public health and social care system" – to 'rebalance' from working for the interests of individual organisations towards all health and care organisations working collaboratively "under one system umbrella."

It does seem that the Government wants to rope Local Authorities into a partnership in which they may have only a single representative on the ICS NHS Body, which will take decisions binding on all NHS providers, which will inevitably affect relationships between the NHS and local authorities, even before the Government has tabled a Bill on Social Care.

NHS Trusts will be judged by their contribution to the ICS plan, **as distinct from** delivering safe and effective care to **their** patients. Tied to financial control on the whole system. Outcomes based. Unwarranted variation i.e. use RightCare or GRIFT.

Finance: changes to Tariff system of payment – 5.51 moving from system of 'payment by results' / ' payment by activity' to payment system to support 'population health' approach.
5.53 " … national price set for that service may be either a fixed amount or a price described as a formula." – that means there can be local variation: "Remove the requirement for providers to apply to NHS Improvement for local modifications to tariff prices."
If it's a block payment, based on population numbers, it will lock in health inequalities unless there is a significant 'deprivation' addition.
Could break down national agreements about pay if ICSs are allowed to make local decisions.



The Queen's Speech in May 2021 and the accompanying briefing notes are light on detail.
And specifically did not include the proposal in the White Paper to scrap Section 75 of the Lansley Bill, unless that's covered by **Removing bureaucratic and transactional processes that do not add value, thus freeing up the NHS to focus on what really matters to patients.**

Briefing Notes say the main benefits of the Bill include Delivering on the proposals put forward by the NHS in its own Long Term Plan, while building on the lessons learned from the successful vaccine rollout.
● Making it easier for different parts of the health and care system to work together to provide joined-up services.
● **Removing bureaucratic and transactional processes that do not add value**
● Enabling the system to most effectively prevent illness, support our ageing population, tackle health inequalities, tailor support to the needs of local populations, and enhance patient safety and quality in the provision of healthcare services. *HOW?*
● Ensuring the NHS and the wider system can respond swiftly to emerging issues while being fully accountable to the public. *Whatever that means*

It says the main elements of the Bill are:
● an Integrated Care System in every part of the country.
● Ensuring NHS England is accountable to Government, Parliament and taxpayers while maintaining the NHS's clinical and day-to-day operational independence.
● Banning junk food adverts pre-9pm watershed on TV and a total ban online.
● Putting the Healthcare Safety Investigation Branch on a statutory footing to deliver a fully independent national body to investigate healthcare incidents,

That sets the scene for where we're up to now. We're going to come on to all the issues raised for campaigning.

The NHSE guidance does add more detail about the ICS structure, as has been covered, but there are still many questions about how ICSs will work in practice. And given the emphasis on ICSs being able to make decisions – about allocation of funding, about the whole plan for services – there could be significant variations rather than a *national* health service.

Issues for campaigning

- **Potential for increased privatisation/private sector control**
- **Unequal partnership for Local Authorities**
- **Workforce issues**

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The following slides will go through each of these points

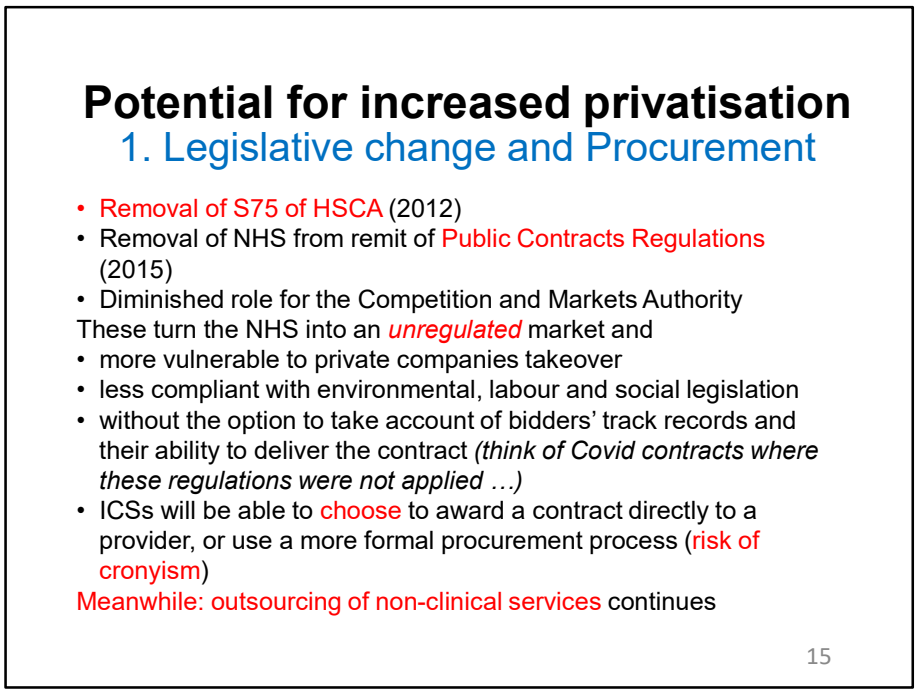
Merseyside campaigners have enlisted a wide range of supporters in their campaigning. The man on the beach looked a bit cold so they covered him up.

The three people with the yellow & blue poster (bottom left) are from the collective campaign Cheshire & Merseyside Stop the White Paper, leafleting hospital staff at 7am at a shift changeover using Konp staff leaflets.

In Merseyside they have been putting up posters in parks, on railings, shopping centres, in cafe/shop windows, anywhere people pass by since last year.
They are using a series of posters and leaflets such as those middle top and bottom right in a social media campaign.

Bessie Braddock MP in Liverpool Lime Street train Station seemed happy to support the campaign.

Please search for their hashtags on twitter and retweet their posts whenever you see them #NHSResistance and #SaveOurNHS



The slide is largely self explanatory.
But just to emphasise – the Purchaser/provider split will remain: "3.15 We will preserve the division between funding decisions and provisions of care."

And Matt Hancock has said publicly that it's 'ideological' and a 'false dichotomy' to oppose the private sector and to say 'public sector good, private sector bad' (this was his response in Health Select Committee to question by Rosie Cooper)

Removing Section 75 of HSCA does NOT mean an end to outsourcing of non-clinical services such as catering, cleaning, portering, security; and some NHS Foundation Trusts are still setting up subsidiary companies and transferring staff – which usually means they lose out on pay and conditions – originally Trusts said it was in order to save VAT. And removing Section 75 does not end tendering for clinical services too.

Removal of the Public Contracts Regulations will make it even easier for private companies to win contracts and they could also participate in the decisions about how contracts are awarded if they have seats on ICS Boards.

Potential for increased privatisation

2. Fragmenting the NHS and increased influence of private sector

- **Fragmenting the NHS: still many providers despite claims of 'collaboration'**
- **Shift from the NHS providing universal, comprehensive care** to focus on groups with high health risks, reduce hospital admissions
- **Shift to Population Health Management, using huge data sets to plan services and reduce costs**

- **Increased presence + *influence* of private companies in planning and running of services, by:**
- Board and Committees membership
- Health Systems Support Framework (HSSF)
- Deregulated market
- **Increased reliance on digital decision-making and therefore on tech companies**

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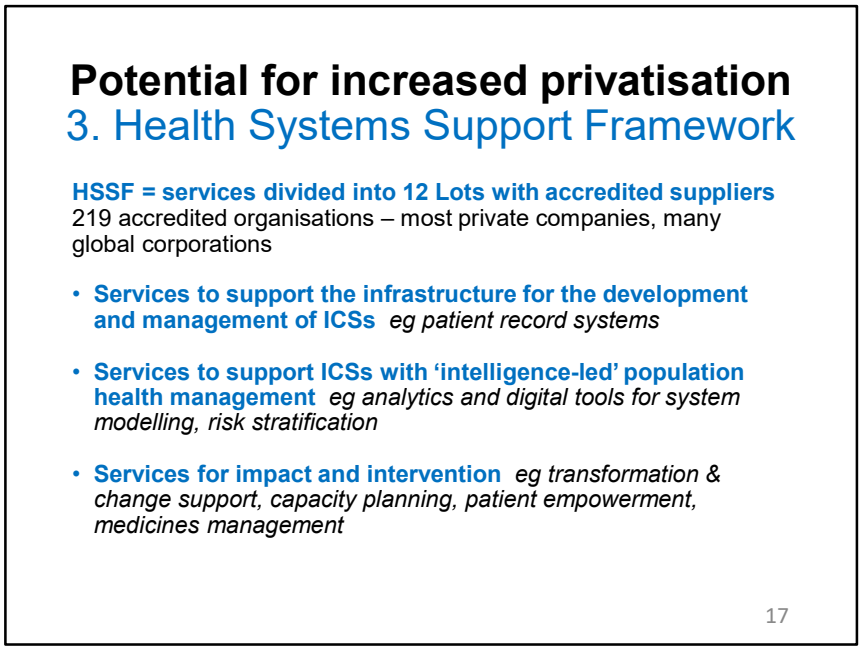
Arguably, the very nature of the NHS is being changed by stealth.

Overall the shift to a population health approach (which is not without some benefits – especially if it was really considering the wider social determinants of health) - fundamentally changes the nature of the NHS from a publicly funded, publicly provided service based on need to a system that focuses on groups with high health risks, and therefore are 'expensive' (eg, hospital admissions).

Population Health Management is a particular population health approach quite a complex concept – it doesn't mean improving the public's health, as you might think. It's about data and finance driving decisions, rather than clinical considerations. In the USA – where the method is used by health insurance companies – it's about managing patient 'demand', identifying and targeting individuals with high risk. It's a data driven approach that focuses on self care and changing health behaviours – that is, it takes a micro level approach to health inequalities rather than acting on the broader social determinants of health. Also, because of the collection of data to do this identification of 'risk' it creates a very valuable data set – who controls that is important. Significantly, it allows increased roles for the private sector.

NHSE guidance shows that the scope for private company involvement goes far beyond Board membership. It includes Committees with delegated powers over spending, expertise on digital and data to inform Population Health Management, and service provision.

We can see what that means in the next few slides about the Health Systems Support Framework. And we'll come back to the digital and data issues later.

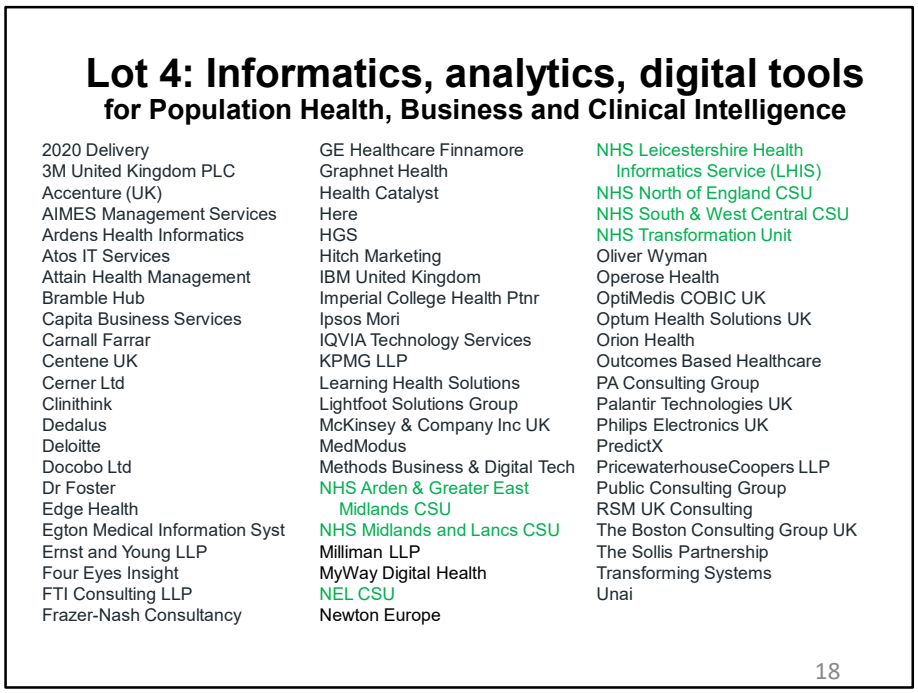


HSSF: https://www.england.nhs.uk/hssf/

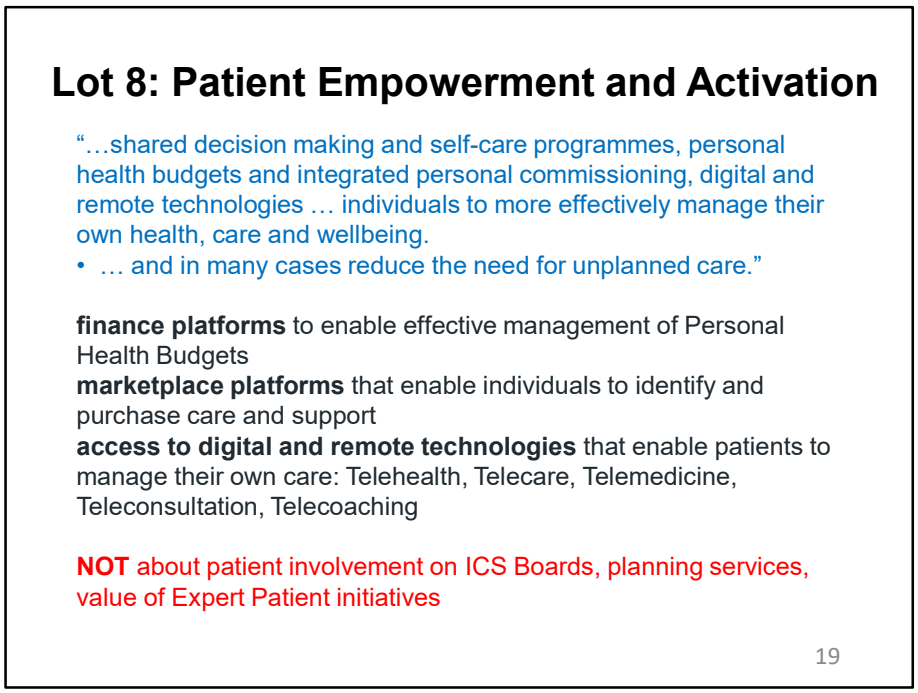
Of the 219, very few are NHS or public sector; there are dozens of US-owned companies including Operose (owned by Centene), Cerner, Optum, McKinsey, Palantir, PA Consulting... And opaque ownership patterns: here's an example:
Allocate Software Limited are accredited for Workforce and leadership support, a category within Transformation and change support (one of the 12 lots)
Who owns Allocate Software?
Allocate Bidco Limited, who are owned by Allocate Midco Limited, owned by Allocate Holdco Limited, owned by Allocate Topco Limited, owned by Antidote Bidco Limited, owned by Antidote Holdco 2 Limited, owned by Antidote Holdco 1 Limited, owned by Antidote Topco Limited, owned by Antidote Investor Holdco Limited - for which the only significant control is Robert Smith
4 Embarcadero Center, 20th Floor, San Francisco, United States, CA 94111

The detail of what these Lots are may seem technical, but this framework is now underpinning the management of systems in the NHS.

NHSE says that HSSF has been structured around three areas:
•**Infrastructure:** encompassing Electronic Patient Records and place-based digitalisation; local health and care records across different care settings; and primary care IT support and cyber security;
•**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;
•**Impact and Intervention:** transformation and change support; patient empowerment and activation (including self-care support, personalisation, assistive technologies and remote consultations); demand management and capacity planning support solutions; system assurance and provider modernisation; and medicines management support.



NHS / public sector organisations in green. The rest are private companies – and look how many are the big finance and management consultants (eg Centene, Deloitte, KPMG, McKinsey, PA Consulting etc
https://www.england.nhs.uk/hssf/supplier-lists/#informatics-analytics-and-digital-tools-for-population-health-business-and-clinical-intelligence

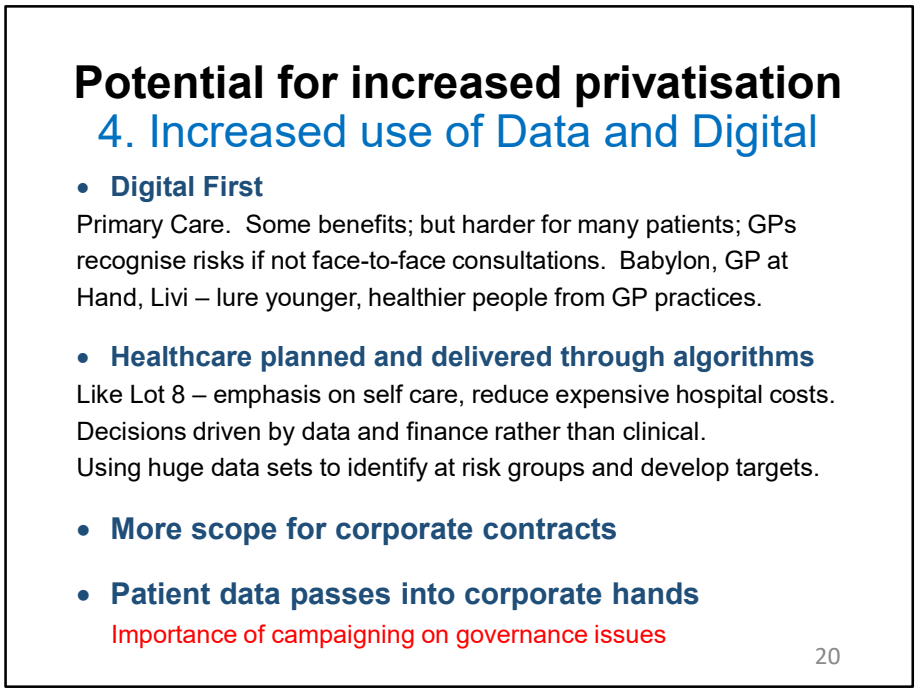


Again, words don't mean all that we might think they should mean. Although there's nothing wrong with supporting people to understand more about their own health and care, this Lot is mostly about digital / remote technologies to help self care (rather than face-to-face care with staff) including financial management of Personal Health Budgets – it's a personalised form of privatisation for individuals to buy health care.

It's not about people being involved in planning the services they need, or on ICS Boards; it says nothing about Expert Patient initiatives.
It is about increasing dependence on private companies.

Take a look at the 'patient empowerment' Lot, to see what it covers:
https://www.england.nhs.uk/hssf/use-framework/#patient-empowerment-and-activation

and the accredited suppliers:
https://www.england.nhs.uk/hssf/supplier-lists/#patient-empowerment-and-activation



Increased use of digital is not specific to ICSs – it's been happening for some time. And obviously some use of digital is good, beneficial for patients – but there are dangers too.
NHSE says: "NHS England is supporting primary care to move towards a digital first approach, where patients can easily access the advice, support and treatment they need using digital and online tools. These tools need to be integrated to provide a streamlined experience for patients, and quickly and easily direct them to the right digital or in-person service.

In practical terms, this means patients should be able to use online tools to access all primary care services, such as receiving advice, booking and cancelling appointments, having a consultation with a healthcare professional, receiving a referral and obtaining a prescription."
But, Dennis Campbell, Health Policy Editor, wrote in a Guardian article 28th March 2021: GPs prefer to see patients face to face, says UK family doctors' leader - Remote consultations feel like working 'in a call centre' and risk missing signs of illness. And there is also the point made about the digital companies luring people from GP practices, that the funding goes with them, so GPs can be left with the more complex patients but less funding.

Use of algorithms: could clearly have beneficial results "new 'alert and action' technology is being introduced which uses algorithms to read patients' vital signs and alert medics to worsening conditions that are a warning sign of sepsis." (Nursing Times, 20 August 2019);

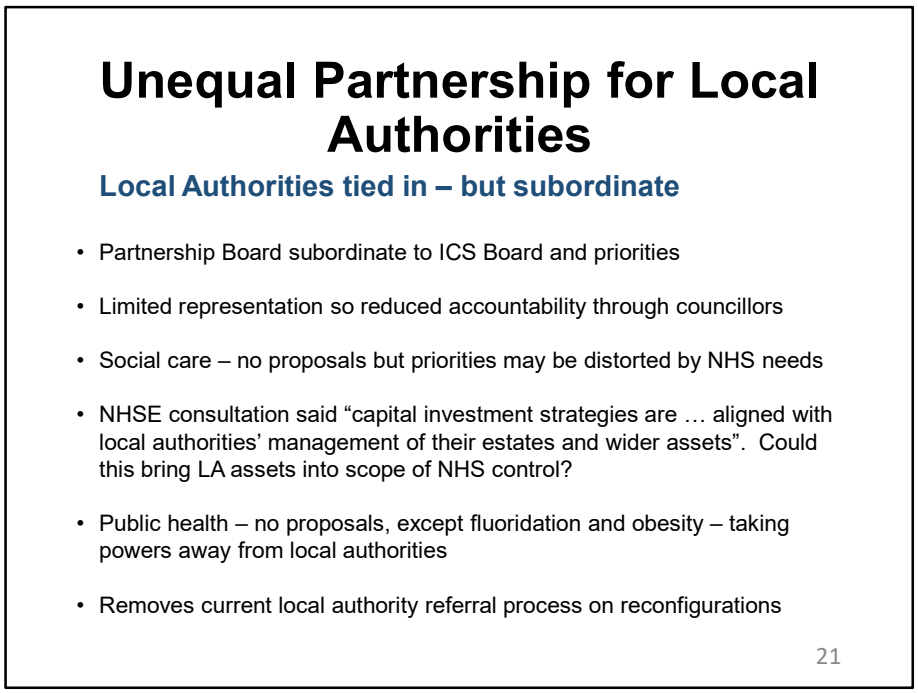
But any digital / apps depend on how the programme is written – still need human involvement. Increased use of algorithms could lead to reduction in clinical judgement, and those who are not digitally literate could be disadvantaged. And need clinicians to recognise when algorithm/computer has got it wrong – remember exam grades fiasco.
Interesting openDemocracy article – links between Greensill and wider use of digital and data by private sector: https://www.opendemocracy.net/en/opendemocracyuk/what-cameron-and-greensill-app-tells-us-about-nhs-digital-privatisation/

The second WEF report: "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.

NHSE guidance says: “We expect digital and data experts to have a pivotal role in ICSs, supporting transformation and ensuring health and care partners provide a modern operating environment to support their workforce, citizens and populations.”

Access for big tech companies to valuable patient data sets.
Too late to prevent tech companies involvement and access to patient data – they are already there. So important to campaign for strong **governance**: no corporates on ICS bodies; no corporate profits to be made out of NHS work; strengthen controls over how data is used.

Patients 4 NHS: Along with allowing data-mining by private companies for a growing range of purposes, NHSE’s plans include increasing the surveillance of individuals’ health and exercise behaviours through collecting data obtained by wearable devices, such as smart watches, that’s then integrated into personal healthcare records. Already the Office of Health Promotion (a new organisation partly replacing Public Health England) is proposing a new monitoring system for those agreeing to wear digital exercise trackers. The system manages to combine surveillance with new commercial opportunities: attaining certain levels of exercise is rewarded by ‘health points’ that can be turned into vouchers and redeemed at participating commercial outfits.



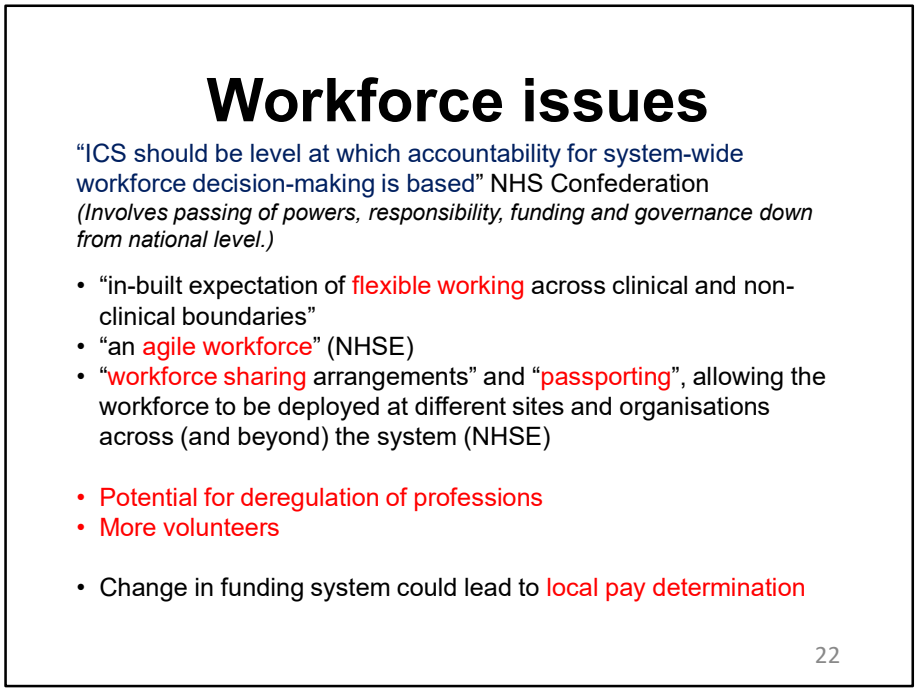
The NHSE guidance says local authorities and the NHS will be equal partners – but only in the Partnership Board, not in the main ICS NHS Body.
The White Paper proposes (**3.11**) "a broad duty to collaborate across the health and care system", which includes local authorities.

All local authorities within an ICS could have just one representative between them on ICS bodies – that's happening already in North London. Local authorities are not happy about this – may be a point on which local authorities are receptive to campaigners.

NHS most concerned about discharging elderly people / people with complex health conditions so as to free up beds – but less than half of local authority social care expenditure is on elderly people – so not the same as the ICS priorities (likely to be dominated by acute hospital sector)
In 2018/19 local authorities spent £12.46bn on social care support: £1.43bn supporting people aged 18-64 with physical and sensory impairments; £5.24bn supporting people aged 18-64 with learning disabilities, and £5.79bn on services for older people (older people are far more likely to be self-funding because of tight financial eligibility criteria). In line with their legal requirements to determine the extent and range of local need, local authorities plan integrated social care support to meet the diverse needs of all their local communities and to address the wider determinants of health.

Local authority resources: "…capital investment strategies: • are not only coordinated between different NHS providers, but also aligned with local authorities' management of their estates and wider assets" (NHSE ICS consultation)

Local authorities currently have right to refer proposed reconfigurations (e.g. service closures) to the Secretary of State, White Paper proposes SoS could intervene at any point in the process, without a referral. And "the **current local authority referral process** will be removed to avoid conflicts of interest."



NHS Confederation reference: Defining-the-role-of-integrated-care-systems-in-workforce-development-A-draft-manifesto.pdf (nhsconfed.org)

Flexibility and Passporting

NHSE guidance" …closer collaboration on workforce development across the health and care sector, and with local government, the third sector and volunteers." "Develop new ways of working and delivering care that optimise staff skills, technology and wider innovation to meet population health needs and to create flexible and rewarding career pathways for those working in the system. This should be enabled by inclusive employment models, workforce sharing arrangements and passporting or accreditation systems."

Flexibility and agility and possibility of working across different organisations and sites – could cause major problems for staff and for trade unions.

Professional Deregulation

5.138 'seek powers to make it easier to ensure that professions protected in law are the right ones and that the level of regulatory oversight is proportionate to the risks to the public, now and in the future.'

5.149 "The UK model of professional regulation for healthcare professionals has become increasingly rigid, complex and needs to change to better protect patients, support the provision of health services, and help the workforce better meet current and future challenges." …

5.150 "This is not about deregulation." But it could be. "over time and with changing technology the risk profile of a given profession may change and while regulation may be necessary now to protect the public, this may not be the case in the future."

It is part of pressure for downskilling, lower banded people taking on higher banded responsibilities; and relies on 'technology' as substitute for qualified staff.

Deregulation of professions due to changing technology assumes that algorithms are risk-free, which is not true. And computer systems fail, even if algorithm is fine. Clinicians need

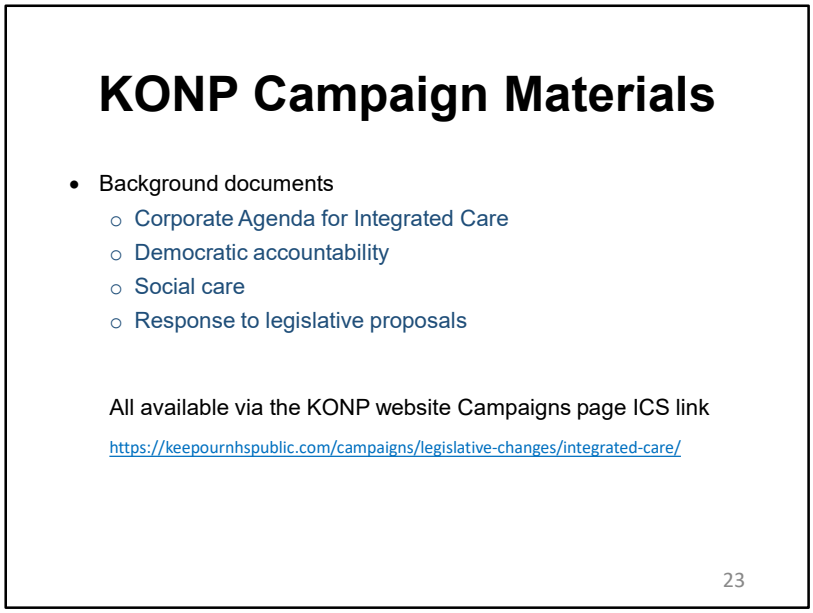
to be able to recognise when computer is giving the wrong answer, and to know what to do.

Finance and Local Pay

NHS England calls for most NHS funding to be delivered through a fixed block payment, based on the costs of the ICS system plan, whose value is determined locally. Local funding levels could threaten national agreements on wages, terms and conditions. Local pay could lead staff to leave areas where funding is cut, further reducing care.

NHSE guidance: p41: The ICS NHS body will agree **how the allocation will be used to perform its functions**, in line with health and care priorities **set at a local level**.

This could allow local decisions on staffing levels, skill mix, pay, terms & conditions.



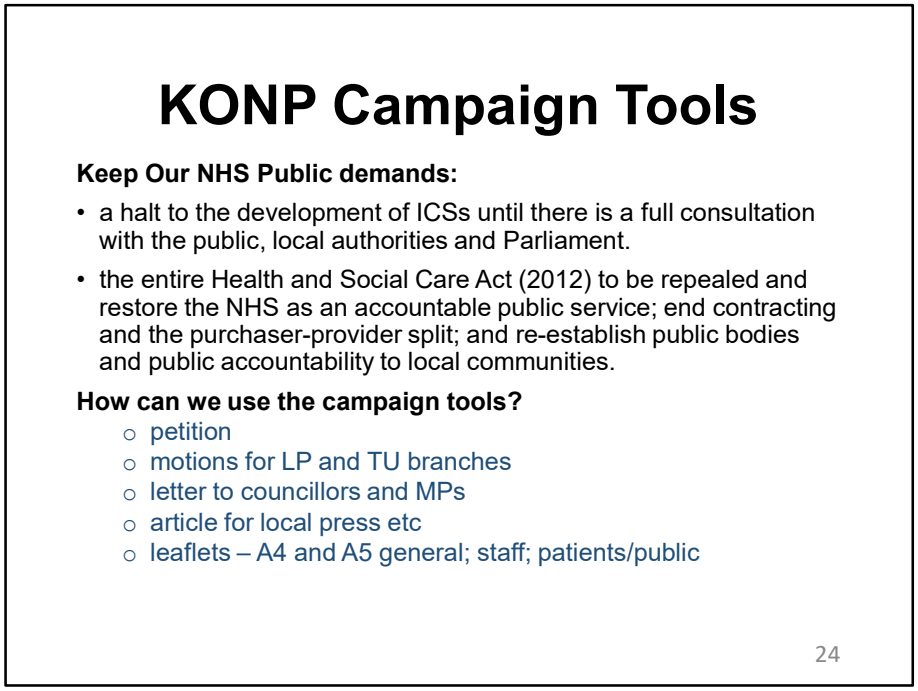
The **Corporate Agenda:** detail about ICSs, where they've come from, what they will mean.

Democratic accountability emphasises what KONP campaigns FOR – a publicly funded, publicly provided, universal, comprehensive service; which should be accountable to local community: "The mechanism for ensuring democratic accountability is through elected politicians at both local and national level." "Local authorities need to develop and safeguard local health services as full partners with NHS clinicians and managers. The alternative is to hand power to individuals and corporations which have no public accountability, with all the potential for incompetence and profit-making that entails. "

Some detail on KONP proposals (if participants want to know more)
The NHS should be developed, managed and provided through a combination of Strategic Integrated Health Boards (for the area/region currently covered by an ICS) and Local Integrated Health Boards responsible for providing services at a local level (referred to as 'place' in NHSEI documents). This is broadly in line with proposals in the *NHS Reinstatement Bill* of 2018 (http://www.nhsbillnow.org/eleanor-smiths-nhs-bill-published-in-full/).

Social Care: some of the main demands KONP makes are:
• A national care and support service, fully funded to meet the needs of a modern advanced democracy through investment in the social infrastructure and progressive taxation, with a national framework setting out entitlements and standards, delivered under local authority management.
• Care and support services to be publicly provided and managed by local authorities with support from not-for-profit organisations, funded through grants, not contracts.
• Community ownership of social care through involvement of service users, family carers, staff and community groups.

Legislative Proposals: the paper is an updated version of one produced when legislation was being discussed in 2019.



The letter to councillors and MPs, article for local press – can have additions to include local information if you know it. Or to councillors and MPs you could ask questions about what they know.

The motions could also be amended (slightly) to include local information.

The motion for the Labour Party could be a motion through CLPs to Labour Party Conference.

The letter and the motions are all very good summaries of the main points of what the White Paper proposed.
They might need to be amended once we see what is actually in the Bill – particularly in relation to opposing incursions by the private sector.

Two new leaflets, one aimed at staff and one at patients / the public, have recently been added.

'Integrated' NHS plans will hurt staff and patients

NHS staff have gone all out to save lives during the pandemic. Many who died could have survived if the Government had ensured full staffing, proper PPE, effective contact tracing and support for people who needed to isolate.

As the virus spread, the Government delayed lockdown, handed out thousands of contracts – some to crony companies with no relevant experience – and spent billions on privatised Test & Trace which did not work.

Now they're restructuring the NHS through a new Health and Care Bill, which will confirm the break-up of the NHS into 42 'Integrated Care Systems' (ICSs) and lead to yet more privatisation.

More than 200 firms, including dozens from the US health insurance sector, are queuing up to develop ICSs. They may sit on ICS management boards and help write their plans, to shape which services will be provided, who will provide them, and where.

Bad news for NHS workers

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Local Information and Questions to Consider

- What do you know about your local NHS structure? (CCGs, Providers – acute, community, mental health, primary care)
- Is it already (virtually) operating as an ICS?
- What are the plans for establishing ICS?
- Where can you find answers if you don't know?
- What links do you have / can you make with Local Authorities (including Health Scrutiny and Health & Wellbeing Committees), Trade Unions, Health Watch, other campaigns, community groups, patient participation groups?

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Important locally to try to find out detail about the difference with what's proposed and what the system is now locally.

Private providers and Legal constraints, will mean even less control for public etc.