Comments on the White Paper on Integrated Care Systems

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for more information on Integrated Care Systems see
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The White Paper (WP) "Integration and Innovation: working together to improve health and social care for all" was published on 11 February: https://tinyurl.com/tepepdfu

The Government has accepted the strategy advocated by NHS England in their consultation on Integrated Care Systems (ICS) which ended 8 January. The WP claims the consultation endorsed the NHSE strategy, which includes:

- population health management
- a Triple Aim to tie the NHS to the interests of the whole system at ICS level
- provision for unspecified partners to join ICS governance bodies
- a new payment system tied to ICS plans with provision for local rates
- data sharing in the interests of the system
- bypassing procurement

The WP is consistent with the underlying aims of NHSE, to convert the NHS to a system aligned to the companies accredited through the Health Systems Support Framework. The KONP material produced in response to the NHSE consultation remains relevant.

The WP also regards the Government response to Covid-19 as a success, paving the way for reform of the NHS to continue the pattern set in 2020. It includes proposals for deregulation of health professionals, whilst claiming otherwise. It would remove the power of Local Authorities to refer reconfiguration proposals to the Secretary of State.

The WP makes clear that the legislative proposals are just one part of a planned wider reform of the NHS. It confirms that the plans derive from the Five Year Forward View.

In preparing the WP, the government consulted stakeholders including the private sector.

I look at these points, without reiterating the earlier KONP responses.

Population Health
The WP mentions "population" very frequently, including many specific references to "population health", a central theme in the Health Systems Support Framework. For example:
1.18 "our experience of the pandemic underlines the importance of a population health approach, informed by insights from data"
2.6 "It is clear that neither the NHS nor local government can address all the challenges facing whole population health on their own."
2.11 "An outward-looking, more connected and integrated health and care system focused on population health, public wellbeing and where technology enabled innovation is possible..."
5.51 "As we move towards a system of ICSs focused on population health, we want to ensure that the payment system supports that direction of travel."
5.54 "we intend to allow the creation of new NHS trusts with the overriding objective of ensuring the health system is structured to deliver the best outcomes for whole population health and respond to emerging priorities."

Duty to Collaborate and Triple Aim

The WP proposes (**3.11**) "a broad duty to collaborate across the health and care system", which includes local authorities. This is explicit at **5.15**:

"This proposal will place a duty to collaborate on NHS organisations (both ICSs and providers) and local authorities. This policy also provides the Secretary of State for Health and Social Care with the ability to issue guidance as to what delivery of this duty means in practice, in recognition of the fact that collaboration may look very different across different kinds of services."

For NHS organisations, there is a related "Triple Aim" (**5.17**):

"a shared duty that requires NHS organisations that plan services across a system (ICSs) and nationally (NHS England), and NHS providers of care (NHS Trusts and FTs) to have regard to the 'Triple Aim' of better health and wellbeing for everyone, better quality of health services for all individuals, and sustainable use of NHS resources."

Whilst "better health and wellbeing for everyone" is undefined, the intention is to tie individual NHS bodies to plans drawn up at ICS level, referred to at **1.20** as "the population health element of our 'triple aim' ". It will also tie them to the interests of the ICS itself. At **5.18** "[The Triple Aim] will support NHS bodies to continue a culture of working together in the best interest of not only their immediate service users and organisations, but of the wider population, and for the ICS as a whole..."

Governance

The WP proposes a new ICS governance structure which incorporates key elements of the NHSE plans, including the option to appoint unspecified partners to the Boards, which featured in the consultation. The details are at **5.6 – 5.8** and **6.18 – 6.22**. Each of the 42 ICS areas will have a statutory ICS NHS body and a separate statutory ICS Health and Care Partnership. The NHS body will take on all the current commissioning functions of the CCGs along with some NHSE functions in the footprint. It will be responsible for developing a plan to address the health needs of the system; setting out the strategic direction for the system; and explaining the plans for both capital and revenue spending for the NHS bodies in the system.

Governance of the NHS body is at **6.18 f)**:

> "Each ICS NHS body will have a unitary board, and this will be directly accountable for NHS spend and performance within the system, with its Chief Executive becoming the Accounting Officer for the NHS money allocated to the NHS ICS Body. The board will, as a minimum, include a chair, the CEO, and representatives from NHS trusts, general practice, and local authorities, and others determined locally for example community health services (CHS) trusts and Mental Health Trusts, and non-executives. ICSs will also need to ensure they have appropriate clinical advice when making decisions. NHSE will publish further guidance on how Boards should be constituted, including how chairs and representatives should be appointed."

The board minimum is specified, but unspecified others can be appointed as determined locally. The unitary board could therefore include private sector healthcare providers, management consultants or population health experts. The extent of local authority representation is also unspecified. It could be one representative for all local authorities in the footprint.

The separate ICS Health and Care Partnership would be tasked with promoting partnership arrangements, and developing a plan to address the health, social care and public health needs of their system. Each ICS NHS Body and local authority would have to have regard to this plan, but what this actually means is unclear. The WP does not specify governance or membership of the Partnership, but states (**6.20**):

> Members of the ICS Health and Care Partnership could be drawn from a number of sources including Health and Wellbeing Boards within the system, partner organisations with an interest in health and care (including Healthwatch, voluntary and independent sector partners and social care providers), and organisations with a wider interest in local priorities (such as housing providers). ... local areas can appoint members and delegate functions to it as they think appropriate.

"Independent sector partners" and (private sector) social care providers are mentioned explicitly, and there is nothing to stop "partner organisations with an interest in health and care" from including consultants or companies accredited under the HSSF. It appears from **6.21** that the ICS will establish the Partnership, with guidance from government.
The relationship between decision-making at the ICS NHS Body and the Partnership is not explicit, and "will allow systems to decide how much or how little to do at these different levels and will also potentially allow them to vary these arrangements over time as the system matures and adapts."

Payment System
NHS funding will now flow through the ICS NHS Body, as CCGs will be dissolved. The purchaser-provider split will remain, as (**3.15**) "a division of responsibility between strategic planning and funding decisions on the one hand, and care delivery on the other".

In line with the payment mechanisms advocated within the US healthcare market by firms accredited under the HSSF, the WP states (**5.51**): "As we move towards a system of ICSs focused on population health, we want to ensure that the payment system supports that direction of travel." Although the details are not included in the WP, (**5.53**) "We will take forward NHS England's proposals on the National Tariff, by amending the legislation to enable the National Tariff to support the right financial framework for integration whilst maintaining the financial rigour and benchmarking that tariff offers." NHSE had more details in a separate engagement in November, advocating a system of block payments and blended tariffs.

The WP states (**5.53**) the intention to "remove the requirement for providers to apply to NHS Improvement for local modifications to tariff prices." Since wages are a major component of NHS spending, this raises the question of whether the Government intends a move to local wage rates in place of Agenda for Change.

Data Sharing
The WP discusses Data Sharing at **5.34**. The WP foresees "a range of proposals to address structural, cultural/behavioural and legislative barriers to data sharing and a more flexible legislative framework to improve data access and interoperability, including enabling the safe sharing of data in support of individual care, population health and the effective functioning of the system". This includes proposals to:
"require health and adult social care organisations to share anonymised information that they hold where such sharing would benefit the health and social care system.
"make changes to NHS Digital's legal framework to introduce a duty on NHS Digital to have regard to the benefit to the health and social care system of sharing data that it holds when exercising its functions."
There is no acknowledgement of the risks involved, as when the US-owned firm PA Consulting uploaded Hospital Episode Statistics data to Google in 2014, or the current involvement of US spy-tech firm Palantir in the Covid-19 data store, eventually revealed under threat of legal action by Open Democracy and Foxglove. Instead, the WP asserts "None of the measures here will erode the protection of personal information".

Procurement
During the pandemic, the Government awarded over 3,000 Covid contracts worth £21.6bn. Many of these were handed out without procurement, some to firms with no relevant experience.
The WP seeks to bypass procurement more widely. At **5.46**, "We will reform the approach to arranging healthcare services and create a bespoke regime that will give commissioners more discretion over when to use procurement processes to arrange services than at present, with proportionate checks and balances." The reforms will (**5.47**) "remove the commissioning of these services from the scope of the Public Contracts Regulations 2015". If this signalled the end of the market in healthcare, it would be welcome. Instead, it means an unregulated market, without the protections in the PCR 2015 under which "contracting authorities may consider incorporating social, ethical and environmental aspects into specifications, contract conditions and award criteria. In addition specific rules have been included for handling abnormally low tenders, and on the exclusion of suppliers who have violated certain social, labour and environmental laws."

5.46 and **5.47** may allow an ICS to award contracts to companies accredited under the Health Systems Support Framework, without procurement and regardless of their track record.

Covid-19 success
On 4 February, an editorial in the BMJ described the government's response to Covid-19 as "social murder", demanding those responsible be held accountable. A week later, the WP claimed the response to Covid as a success, whose lessons inform the ICS proposals. In the **Foreword**, the WP "aims to build on the incredible collaborations we have seen through Covid and shape a system that's better able to serve people in a fast-changing world". At **1.4** "Our legislative proposals capture the learning from the pandemic… they make permanent the innovations that Covid-19 has accelerated". At **1.18** "our experience of the pandemic underlines the importance of a population health approach, informed by insights from data". At **2.3**, the Covid-19 response is cited as one of the Government's achievements, including the Data Store though without mentioning Palantir.

Deregulation
From **5.148 – 5.156** the WP proposes changes in the system of professional regulation. Despite claiming at **5.150** that "this is not about deregulation", the next sentence explains "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." How the advent of new technology would remove the need for regulation of those who use it, is not explained.
At **5.154 a)** the proposal includes "the power to remove a profession from regulation", and "A provision to enable the removal of a profession from statutory regulation through secondary legislation will make it easier to ensure that the protections and regulatory barriers that are in place remain proportionate for all health and care professions."
At **5.154 b)** "the power to abolish an individual health and care professional regulator."
At **5.155** "This change would allow the Secretary of State to exercise this power and enable Parliament to abolish a regulator using secondary legislation, where its regulatory functions have been merged into or subsumed by another body or bodies, or where the professions that it regulates are removed from regulation.
At **5.156 c)** Regulators are currently restricted from delegating to another body some of their core functions… The removal of these restrictions would enable a single regulator to take on the role of providing a function across some or all regulators."
Even without removing professions from regulation, this would reduce the capacity to actually regulate, by cutting the staff involved.

As this section runs to 3 pages, it signals a real intent to reduce regulation of health professionals, raising questions of public safety, and suggesting an aim to replace fully trained, qualified staff.

Reconfiguration
Currently, local authorities have the power to refer proposed reconfigurations (e.g. service closures) to the Secretary of State, using the Independent Reconfiguration Panel which has advised on 80 cases since 2003. At **5.83**, the WP proposes to allow the SoS to intervene at any point in the process, without waiting for a referral. If that sounds good, at **5.84** the WP explains "we will issue statutory guidance on how this process will work as well as **removing the current local authority referral process** to avoid creating any conflicts of interest... we expect the Independent Reconfiguration Panel to be replaced by new arrangements."

wider reforms planned
The WP makes clear that the legislative proposals are only part of the Government's reform plans for the NHS. The payment proposals at **5.53** are not fully specified. The "bespoke health services provider selection regime" (**3.15**) is yet to be explained. The forthcoming Data Strategy for Health and Care (**5.34**) has yet to appear.

from FYFV to present
The WP openly acknowledges that the current proposals developed from the Five Year Forward View unilaterally announced by NHSE in 2014. The timeline is shown in a box at **2.10**, from the FYFV through the Vanguards testing new models of care (2015), STPs (2016), ICSs (2018), Long Term Plan (2019), and the latest NHSE consultation.

But there is no hint as to where the FYFV itself came from. As Stewart Player discovered, the FYFV originated at the World Economic Forum at Davos in 2012-13, in two reports developed by McKinsey and Company in working groups, one of which was stewarded by Simon Stevens, at that time President, Global Health, UnitedHealth Group, and later appointed as NHSE Chief Executive. The FYFV simply implemented the WEF reports. The second report included a vision of the UK health system in 2040, in which "Investments and decisions will be driven by value and data" and citizens will "share some of the cost of their elective care".

The alignment of the White Paper with the agenda of the companies accredited under the Health Systems Support Framework is no coincidence.

Stakeholders
In preparing the White Paper, the Government consulted with a range of Stakeholders, including Care UK and the Independent Healthcare Provider Network. The IHPN has 65 members in England, including Bupa, Capita, Circle, HCA Healthcare, Inhealth, Operose, Optum, SpaMedica, Spire, Virgincare.
Optum, owned by UnitedHealth, is a US healthcare corporation with an annual turnover of $100bn.
Operose is owned by Centene, a US health insurance firm involved in Accountable Care through its 90% ownership of the Spanish company Ribera Salud.
Circle is best known for the Hinchingbrooke Hospital debacle.