KONP comments on *Integrating Care – The next steps to building strong and effective integrated care systems across England* [1]

2. ICSs: An alternative vision: achieving democratic accountability

The model for ICS promoted by NHSEI and set out in *Integrating Care* uses the rhetoric of collaboration and putting patients at the centre while in reality embedding privatisation and financial priorities at the heart of the NHS.

KONP rejects the ICS model of priorities and system management except for one important aspect: the proposal to re-establish regional-based planning organisations within the NHS. This is a welcome development following the chaos of fragmentation generated by the 2012 Act. The current ICS configurations provide a basis on which an alternative structure of Integrated Health Boards can be developed.

The mechanism for ensuring democratic accountability is through elected politicians at both local and national level.

At national level, responsibility for providing comprehensive health services to meet the needs of the population must be restored to the Government and the Secretary of State with responsibility for health and social care. At local level, local politicians should share responsibility for NHS services through local democratic structures as set out below.

Whatever the failings of political representatives, the answer is not to strip them of responsibility for public services, but to enforce greater accountability. 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.

Funding:

National responsibilities of the Government and Secretary of State must begin with ensuring the NHS is fully publicly funded to provide comprehensive healthcare to meet the needs of the population. Current funding falls well below levels in comparable economies such as Germany or France, and this is reflected in the UK's far fewer numbers of doctors and hospital beds as well as the crumbling fabric of much NHS estate. The NHS will never be able to meet population needs so long as it is chronically underfunded.

A publicly provided service

KONP advocates a truly integrated NHS, with services that are publicly planned and publicly managed. KONP seeks the abolition of the purchaser-provider split with its notion that health services should be procured and managed through commercial contracts. NHS services should be provided as a public good, and profit motives should play no part in the

[1] https://www.england.nhs.uk/integratedcare/integrated-care-systems/

provision of core NHS services including in planning and management of the NHS as well as direct clinical and support services.

Re-establishing public capacity: ending the culture of corporate consultancy

National responsibilities also mean ending the corrosive culture of corporate consultancy within the NHS as well as elsewhere in public services. The problems are widely recognised. In September 2020, Lord Agnew, the Cabinet Office and Treasury minister wrote[2] to senior civil servants demanding they rein in the spiralling costs paid to private firms and stop 'depriving our brightest [public servants] of opportunities to work on some of the most challenging, fulfilling and crunchy issues'. Such issues are especially relevant to the NHS, where the vital clinical expertise of health professionals, the detailed understanding of local communities possessed by local and regional elected authorities and the vital input of patients and local communities have been all but ignored.

Instead, unaccountable management consultants have been imposed on the NHS. Their vision is corporate and their brief, as demonstrated in Part 1 of KONP's response, is overwhelmingly managerial and financial. These functions are important but should always be secondary to the primary purpose of the NHS - to provide comprehensive and effective healthcare to meet the needs of the population. It is vital that the NHS and local authorities are supported to develop the in-house expertise needed to undertake strategic planning and full management of these public services.

This will require an emphatic commitment at national level and throughout the NHS to recreate and develop a cadre of values-driven, skilful middle and senior level managers. The NHS has been able to resist many top-down directives and operate in a public interest-led way because of the strength of the professional and public service values that drive its key groups of staff. It is critical that the voices of working health professionals are heard loudly and clearly in any new devolved decision-making structures, as well as being heeded at the highest level through the system of royal colleges and faculties. In the interests of integration of services across silos, it is also important that training and career development build systematic links across boundaries in order to work optimally on the wider determinants of health inequality. Human resources must also be adapted to support these developments and eliminate support for values that are not in the public interest.

The need for the NHS to be democratically accountable

In its own response to *Integrating Care*[3], the Local Government Association (a cross-party body that reflects virtually all local and regional authorities across all political persuasions)

[2] https://www.theguardian.com/politics/2020/sep/29/whitehall-infantilised-by-reliance-on-consultants-minister-claims

[3] https://www.local.gov.uk/parliament/briefings-and-responses/lga-response-nhs-england-and-nhs-improvement-consultation

has stressed that these proposals are not a genuine partnership with local authorities but reflect a top-down NHS approach and risk bypassing important existing local partnerships.

> *In our view, the ICS as currently proposed will be an NHS body with local government representation, not a partnership of equals across the whole system. Calling this body an integrated care system is to us a misnomer because it is primarily an NHS body*
>
> *We are concerned that the changes may result in a delegation of functions within a tight framework determined at the national level, where ICSs effectively bypass or replace existing accountable, place-based partnerships for health and wellbeing.*

The LGA also points to the vital opportunities lost by not including local authorities as genuine equal partners:

> *But the proposals are in danger of missing the real prize of collaborative place-based leadership to achieve greater investment in prevention and community-based health and wellbeing services, including a far stronger emphasis on mental health. It is only by addressing the wider determinants of health – safe and affordable housing, access to training and good jobs, a safe and healthy environment, support for early years, infrastructure to support resilient communities and other encouraging our citizens to take an active part in their neighbourhood – that we will ensure accountable, sustainable and effective health and care systems that address health inequalities and improve population health.* ***And it is only by working in equal partnership with local government that the NHS will be able to achieve this.***

KONP strongly endorse these comments from the LGA.

Strategic Health Boards and Integrated Health Boards

In place of the NHSEI proposals, the model for the future of the NHS should be truly collaborative, genuinely put individual patients and public health at its heart and be publicly accountable at national and local level.

An effective NHS must be based on the vital pillars of clinical expertise, national and local priority setting with public accountability, and responsiveness to patients and communities.

Integrated Health Boards

KONP propose 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). These proposals are broadly in line with those in the *NHS Reinstatement Bill* of 2018 (http://www.nhsbillnow.org/eleanor-smiths-nhs-bill-published-in-full/). The pandemic has highlighted the need to strengthen development of public policy-

making at sub-regional level and sub-national levels, and future developments of Health Boards should be aligned with these.

Integrated Health Boards should be responsible for the entire population living within their area, with funding reflecting the whole population and not, as with current CCG funding, matched to just those patients registered with GPs in the area.

The boards should be responsible for all primary, secondary and tertiary medical services, dental, hearing, ophthalmic and pharmaceutical services and community services, mental health and well-being services and public health services.

This would include assessing the needs of the public in relation to their physical or mental health, planning services to meet those needs, setting clinical standards, matching funding to delivery within the area of the board, collecting and processing information to support the provision of health services, ensuring accountability within the provision of health services.

To safeguard the NHS as a public service, Integrated Health Boards should be prohibited from providing services or facilities (including hospital accommodation) to private patients or from making arrangements for primary medical services with commercial companies under section 83(2) of the National Health Service Act 2006.

Involvement in Integrated Health Boards

Proposals for Strategic and Local Integrated Health Boards should be prepared jointly by NHS bodies and local authorities. A wide range of 'stakeholders' should be involved in developing proposals, including NHS staff and clinicians, GPs and their staff, local authority public health and care staff, patient representatives, voluntary organisations, trade unions, and health academics. Health Boards should be geographically broad enough to do strategic planning and local enough to allow real involvement in decision-making by staff, patients and communities.

Proposals for the establishment of these boards and transfer of functions should seek to minimise disruption to the provision of services, and to patients, clinicians and other staff employed in providing services.

Local Health and Well-being Boards consist of senior officers and leading members of councils with membership from CCGs, other ex officio posts such as Directors of Public Health and others such as representatives of the local voluntary sector. In most localities, HWBs have been sidelined and play little or no part in strategic planning. However they might be given a much more significant role and developed as the key body for making well-integrated decisions at place level. There is also a need to strengthen the role of directors of public health, creating additional powers – for instance, to require Government to provide information about their locality - and making them personally accountable.

Community Health Councils

In each Local Integrated Health Board area, the Secretary of State should establish a Community Health Council to represent the interests of the public in the health service, including scrutiny and review of service provision, proposals for service development and scrutiny of Integrated Health Board proposals.

Timeframe

The changes proposed address the need to integrate planning across the wider determinates of health in full partnership with local authorities and NHS staff. This, together with the development of new democratically accountable structures and ensuring the appropriate level of subsidiarity will require considerable time. In addition, we need to ensure that important lessons arising from the pandemic have been learned before making major changes.