The Government White Paper on Health and Social Care 2021

A briefing for councillors from Save Our Hospital Services, May 2021

The Government's White Paper '[Integration and Innovation: working together to improve health and social care for all]' (Feb 2021) sets out proposals for the future management of the NHS and social care, merging the current NHS Clinical Commissioning Groups with other care providers - including Local Authorities - into 42 'Integrated Care Systems'. The consequences for Local Authority accountability, models of care, funding and service provision are far-reaching.

The Government has chosen the aftermath of the worst pandemic for 100 years, when health and care professionals are exhausted, and local representatives distracted, to drive through these changes. We believe councillors deserve to know the real motives behind the proposals and the likely consequences for the people they represent.

The proposals

The primary purpose of the reconfiguration is to **control costs**, '*with a duty placed on the ICS NHS body to meet the system financial objectives*'. Unlike the CCGs they replace, ICSs will have no freedom to operate a deficit budget. Instead they will receive a fixed budget for a fixed population. In some models, managers who make savings against this budget can take a share in the difference - we already see some GPs being offered incentives not to refer patients for hospital services.

These systems have been trialled in various places around the UK but according to the National Audit Office *'have not yet established a robust evidence base to show that integration leads to better outcomes for patients'.* The Health and Social Care Select Committee Inquiry into ICS in March 2021 heard from NHS representatives and health think-tanks that **neither cost savings nor benefits to patients** have been demonstrated, despite seven years of concerted effort. Integrated Care Systems have been implemented in the US, where they have become known as '**denial of service**' systems for their refusal to pay for care, and their efforts to drop 'high-risk' patients. They have also been tried in Spain, where they were eventually re-integrated into the public sector after a spate of financial and governance failures.

A population-based or 'capitated budget' approach makes some sense in an **insurance-based system**, but no sense in the NHS. The simplicity and efficiency of our model comes from its whole-population approach, including national assessment (through NICE) of the best clinical treatments and approaches. Everyone in the country benefits when everyone's health is looked after, regardless of their ability to pay. There are concerns that the White Paper may pave the way for an insurance-based model, especially as many of the people shaping it at the NHS and Department of Health have spent their careers in the private healthcare sector and in consultancies and think tanks that are pushing for this approach.

Put simply, an ICS incorporates the management of all of health and social care for a population, including the NHS, Local Authority funded care, community and third sector care, and the private sector. A single Board decided how the fixed budget is distributed. **The principle of a *national* health care system is lost**, introducing a wide range of different and potentially competing models of allocating and managing funds - a true postcode lottery.

In the current proposals, NHS representatives will always outnumber those from local government. So **local authorities will remain responsible** for delivering social care, public health, and all the wider determinants of health, but have little say over the funding they receive, and no powers of scrutiny over local NHS decisions as they have at present.

Commercial contracts will remain, and **further contracts will be awarded to private companies**, including contracts to run integrated care systems themselves, and a plethora of central services in digital, finance, logistics, infrastructure and estates. There will be more, not less, private provision - already estimated at between 25 and 27% of NHS spending. And commissioning will be removed from the Public Contracts Regulations 2015, so contracts can be awarded without any tendering process and with no safeguards against corruption or conflicts of interest (what could go wrong?).

At the same time, the **Secretary of State for Health** is taking on new powers, including the power to commission social care directly, and to set up new Trusts and NHS bodies that could be run by the private sector. For example it was recently announced that the entire NHS diagnostic imaging service may be separately outsourced.

No accountability

ICS Boards will take on the financial and oversight roles of a number of public bodies, including local council scrutiny committees. But there is **no requirement for them to include democratic representatives**, to meet in public, or to be accountable to public scrutiny (e.g. through the National Audit Office or the Freedom of Information Act).

There are **no controls over who sits on ICS Boards** - they could include private providers and management consultants, even contract holders (remember, transparent tendering has been removed). There are no mechanisms for community involvement at the system level, and it is unclear how LAs will be represented. Local authorities are asking who will commission and determine the budgets for social care, public health and children's services. Who decides where patients end up receiving care in this complex system, and whether it will be NHS or LA funded, or means tested for individuals to pay?

What is clear is that the Care Quality Commission will **hold LAs accountable** for the performance of underfunded and crisis-ridden services, while the national review of social care that was promised by the Government has been kicked down the road.

Local government scrutiny committees will be cut out of the role they currently have to provide **oversight of NHS service reconfigurations**. GPs, hospital trusts, ambulance trusts and care services will be encouraged to merge or form networks to find further 'economies of scale' - and this will **remove accountability further from patients** and their local representatives. Despite the rhetoric about undoing some of the gross inefficiencies of the internal market, this is in fact another step to embed the market reforms of the last two decades, not the re-instatement of the NHS as a fully public body, as a majority of people in the UK want.

The new ICS footprint areas do not coincide exactly with Local Government footprints, so it is unclear how Boards will ensure democratic representation of all communities.

The fact that these plans are being put forward in the middle of the biggest **public health crisis** for a century - with a public consultation process over 6 weeks of Christmas/New Year - means that

proper public scrutiny is being undermined. The planning of the Bill has been shrouded in secrecy, with management consultants and think tanks at the heart of it, and local authorities pushed to the side. ICS CEOs have already been appointed, and in many areas 'shadow' ICS boards are already meeting, in defiance of the need for primary legislation and full parliamentary scrutiny.

Cuts to NHS services

The 'model of care' that has been pursued by successive NHS planning cycles and is being consolidated in the White Paper aims to **reduce access to hospital beds and services**. In March 2021, the Royal College of Emergency Medicine told the Secretary of State that bed capacity must be restored to pre-COVID levels and an additional 9,429 beds installed and staffed to achieve safe levels of bed occupancy. Thousands more beds and nurses would be needed to bring the UK up to the levels of other leading European economies. But under the ICS proposals, **bed numbers will continue to fall.** There will be just 40-70 major trauma centres. District and community hospitals will continue to be closed, with services 'rationalised', increasing the risks to rural communities.

GPs and other primary and community care providers will be expected to step in, picking up 111 referrals, intermediate care, minor injuries and clinics. GP practices will be encouraged to merge to provide economies of scale, making **GP chains vulnerable to buy-outs** - like the 70 London GPs just taken over by Centene, a US healthcare corporation. Care will be relocated from hospital settings to the community, but the community will not receive more medically qualified and experienced staff. With services pushed out of the NHS, and local authority budgets already cut to the bone, it seems likely that **more care will be paid for by the individuals receiving it**, and/or provided by low-paid care workers.

In rural areas, 111 services already have **nowhere to refer people in crisis** (no MIUs, community hospitals, walk-in centres) and GPs are not able to pick up all these additional needs. Emergency admissions of frail and elderly patients, and emergency readmissions after discharge are all rising, and Emergency Departments are seeing more demand from people in deprived areas who have nowhere else to turn. Apart from the unnecessary suffering, these unmet needs create further demands on community services.

Finally, despite the many problems caused by the 'GP at hand' service and other digital 'alternatives', **digital apps will increasingly be used** to provide the NHS front line, triaging patients, undertaking diagnoses, signposting services (including LA services), and providing health advice. Local government has been cut out of consultations about the large-scale use of digital solutions and data records, and the process of contracting private companies to provide them. There are still no clear commitments to share data with local public health teams, for example.

No solutions for social care or public health

The real barrier to integrated care across the life course is not NHS structure but the **crisis in social care**. In March 2020 (pre pandemic) the CQC's Market Analysis found that the **adult care system was extremely fragile**, with any shocks likely to drive many providers out of business, place more pressure on LA finances, and increase unmet care needs. In June 2020 over a quarter of Directors of Adult Social Services said that they were concerned about the financial sustainability of MOST of their providers of residential care. The White paper does nothing to address the long-term sustainability of the sector.

Turnover rates for care workers are close to 40% nationally - worse in many regions - and reduced access to hospital-based care will place further burdens on this workforce. The White Paper puts off any consideration of the needs of the **social care workforce**, though Matt Hancock said in evidence to the Health and Social Care Select Committee (March 2021) that he considered the Minister should be responsible for workforce planning rather than 'experts'.

Care for the long-term sick and elderly in the community, end-of-life care and intermediate care all require highly trained staff. Integrated budgets with capped costs will provide big **incentives to move care to wherever in the system the costs are lowest**, including the costs of staff and their skills. Once again the pressure to make this work is likely to fall on local authority services.

Under the proposals, a new '**discharge to assess**' model will allow patients to be discharged from hospital before any assessment of their ongoing needs (currently an assessment must be carried out by a specialist discharge nurse). Mental health advocates have called this a 'licence to forget' patients. More than half of all current mental health trusts have called the White Paper a 'step backwards' for their services.

Already, the NHS purchases many **private care-home beds** to fill the gaps left by community and district hospital closures, and to meet the demand for early discharge. The prospect of central purchasing of private social care by the Secretary of State brings private nursing care even more centrally into the NHS. Yet there has been no map of what is expected from Local Authorities.

Councillors will be well aware of the sweeping **cuts to public health** over the last decade, and the consequences as the country entered the Covid-19 crisis. A new body, the National Institute of Health Protection, has been established under the leadership of Dido Harding, with no clarity about the ongoing role of local public health teams. And the White paper includes no concrete commitments to a preventative, public health approach other than fluoridation of water. There is no recognition of the need to address the wider determinants of health - access to secure housing and jobs, a healthy environment, reducing deprivation and income inequalities, education and early years care, community infrastructure - despite a supposedly 'joined up' approach.

Corporate interests consolidated

The White Paper has been hailed as a solution to the huge costs and inefficiencies of the **competitive internal market** that was imposed on the NHS by the 2012 Health and Social Care Act. The LSE estimates that the NHS now spends more than a quarter of its funding in the independent sector, including huge sums on management consultants to make sense of the complex partnerships, contractual arrangements and accountability structures (though the evidence is that they make things worse).

However, while removing some elements of competition, the ICS structure will give corporate interests a stronger hold on the NHS:

- **contracts** will continue to be made available to private providers, but now without the requirements for an open and transparent tendering process
- private providers can now sit on **ICS Boards**, with control over budgets, governance, and contracts (that they can bid for)
- there is even more scope for management consultants to oversee the complex contracts and 'transformation plans' of 44 new ICS partnerships
- the NHS is looking to massively expand its existing contracts with **private hospitals** to help deal with post-pandemic waiting lists.

- corporates are also becoming embedded in the **core systems** of the NHS under the Health Systems Support Framework, especially digital, financial, logistical and property services

As with CCGs before them, ICSs will in fact be **competing with one another** to show efficiencies. Those that are found wanting may be vulnerable to being taken over by more 'successful' systems - the biggest, most corporate and most aggressively cost-cutting.

Local councils also need to be aware of how local **NHS estates are being reconfigured** to support the new models of care. Publicly owned buildings are sold off rather than being upgraded, and new private finance initiatives are put in place to build elective care centres and health 'hubs' with flexible space that can be leased to the NHS, primary care providers, and anyone else who can afford to pay: cafes, pharmacies, wellbeing 'services', private healthcare providers. These 'hubs' are not public buildings but rentier enterprises. The evidence so far is that the voluntary and third sector organisations that are crucial to bridging the gaps in care are unable to afford space in them.

Key messages

Campaigning against this complex piece of legislation requires simple messages.

- NHS services will continue to be lost at a local level - community and district hospitals, surgeries, walk-in centres, community clinics and minor injury units.
- The NHS will no longer be accountable to local authority (LA) scrutiny
- LA representatives will be in a permanent minority on the joint decision-making boards for health and social care
- LAs will remain responsible for delivering social care, public health, children's and adult services, and all the wider determinants of health, but without control over how budgets are allocated within the local health and care system
- Rationing of hospital-based care will place greater demands on social and community services (as well as primary care)
- Digital health will be prioritised for development and in time will become the first line of access to the NHS, with online advice and diagnostics replacing face to face consultations.
- Patients' voices and concerns will be lost in merged provider networks and bureaucratic systems
- Private interests are being embedded into the NHS - not just providing care but running organisations, sitting on boards, deciding budget allocations and models of care, and providing major parts of NHS infrastructure (especially digital and logistics)
- Corruption and cronyism will become rife, as contracts are awarded with no transparency or competitive tendering
- Personal health care records will be available to private corporations

Integrated care systems are a failed experiment in sharing risks and profits within insurance-based systems. They have no place in the NHS.

Links to other briefings/responses

These are provided for information and do not represent the views of SOHS.

- BMJ 11/02/21 (Op-Ed by Peter Roderick and Alyson Pollock): 'The wrong proposals at the wrong time'
- Keep Our NHS Public response on ICS and privatisation

- Motion from Doctors in Unite calling for a return to local Health Boards instead of ICS
- Critical response from the Local Govt Association
- 'The Dying Days of Local Accountability', John Lister in The Lowdown
- 'Significant concerns' from PulseToday
- Detailed commentary on the proposals from Greg Dropkin on LabourNet
- More than half of all current mental health trusts have called the White Paper a 'step backwards' for their services