NHS
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Oxfordshire KONP Briefing

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Reorganisation of the NHS: Integrated Care Systems

In February, the government published its White Paper on the reorganisation of the NHS and the creation of Integrated Care Systems (ICSs) as statutory bodies. These ICSs will replace local Clinical Commissioning Groups as the organisers and purchasers of health services. The legal requirement introduced in 2012 that commissioners had to open health contracts to competition on the market has been removed but it's not clear what the new procurement rules will be or how private sector involvement will be regulated.

Integrated care systems
Where next?

Health professionals and campaigners have raised a number of concerns about the proposed legislation. These have to do with accountability, the role of local authorities, the failure to integrate social care, the new powers of the secretary of state, and the role of the private sector.

Accountability

Currently there are over 130 clinical commissioning groups in the English NHS (reduced from over 200 as a result of mergers). These will be replaced by around 40 ICSs and the aim is to radically reduce this number, creating wider regional ICSs. It's not at all clear how these larger statutory bodies would be accountable to patients, residents and communities at each of the three levels of the intended structure, described in the white paper as neighbourhood, place and system levels. For instance, there is no requirement that the ICS Board will meet in public, publish board papers and minutes, be subject to the Freedom of Information Act 2000, or engage with local residents.

Diminished role for local authorities

In the current structure of healthcare in England, each local authority has a statutory committee, the Health Overview and Scrutiny Committee, which has a legal duty to scrutinise the effects of decisions by NHS or government bodies on local population health. This committee has the legal right to challenge such decisions and the Secretary of State can refer any challenge to an Independent Reconfiguration Panel. In the present system, therefore, there is a level of accountability of the NHS to local authorities and populations. In the present White Paper, this accountability is removed. The White Paper states explicitly that, while local authorities are accountable to the people, the NHS is accountable to the government. This completely undermines and reverses the traditional understanding of accountability in the area of public service.

ICS Boards will make legally binding decisions about major resource allocation and service provision. As the composition of these Boards will be 'flexible' and determined by

the ICS, and could include representatives from a whole raft of providers, including nursing home chains, the local authority could well find itself outnumbered and unable to promote the needs of our local population.

Social care not integrated

The White Paper offers no solution to the problem of social care. We currently have an almost wholly socialised state healthcare system operating alongside an almost wholly privatised social care system. Until social care is removed from the market, any notion of integrating it with the NHS is meaningless. The White Paper solution is to create a second board at ICS level, the ICS Health and Care Partnership Board. In addition to NHS officials and representatives of local authorities, this board will also contain representatives of private providers who will be involved in decisions about provision and assessment of need in spite of the obvious conflict of interest. The reform of social care has, once again, been pushed into the long grass.

New powers for the Secretary of State

The White Paper hands new powers to the Secretary of State. The argument for this is the need for greater flexibility and the experience of the pandemic which demonstrated the need for quick decisions at the top (PPE, test and trace!). The present government's preference for top-down decisions, which we saw in the pandemic as well as in proposals for local planning, will now be extended to the NHS. The Secretary of State will have the power to directly intervene in any reconfiguration of health services. This is presented as designed to enable "speedier local decision making". This could mean closing down a local service or overruling a decision by a trust or local authority.

The right combination of a unified NHS, in which the Secretary of State is responsible for healthcare, with local democracy and accountability can be difficult. When the government of the day has underfunded and undermined public services and demonstrated a clear preference for private sector provision, campaigners need to be vigilant and prepared to challenge government decisions. As a very minimum, we need to demand the restoration of the overview and scrutiny function of elected local authorities.

In addition to the power to oversee and regulate ICSs, the Secretary of State will also have the power to "transfer functions to and from specified ALBs". These are arms length bodies, sometimes called quangos, publicly funded but not publicly run. The Secretary of State will also have the power to transfer public funds directly to private firms "which are engaged in the provision of social care services in England".

Role of the private sector

Has the removal of the need for competitive tendering ended or reduced private sector involvement in NHS provision of healthcare? There are certainly reasons for scepticism about a government change of heart on private provision. There has been stiff criticism of the top-down PPE procurement process after billions of pounds worth of contracts were awarded without competitive tender, with other generous contracts going to individuals with ties to the Conservative Party.

The public consultation

In February, the government also began a consultation on a new Provider Selection Regime, on what rules commissioners should follow in future when purchasing health-care. Competitive tendering has not been abolished: "We want competitive tendering to be a tool that the NHS can choose to use where appropriate". The initial document sets out a list of criteria which health bodies and local authorities must consider when choosing a provider, for instance, quality, value, innovation, patient choice and sustainability. But none of these criteria place a positive value on public or in-house provision. Nowhere does the concept of integration used suggest that services currently tendered on the private market should be brought back into public provision.

There are 9 questions in the public consultation, for instance, should the NHS continue with the current provider, should the NHS award a contract without competitive tendering, etc. But it doesn't ask if the respondent would prefer in-house over private provision where this is possible. It doesn't ask if we'd prefer to keep our existing CCGs or maintain the right of Health Overview and Scrutiny Committees to challenge decisions affected people's health. It's only in the final question which asks for general comments, that we can express any real criticism of this proposal.

What can you do?

The consultation ends on 7 April. You can find it here. The organisers of these consultations tend to lump together and ignore input from campaigning organisations so it's generally better to respond as an individual. It's also a good idea to let your MP know what you think about this reorganisation of the NHS. You can always contact your MP or local councillor from this site.

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