

**NHSE/I consultation on**  
**“Integrating care: Next steps to building strong and effective  
integrated care systems across England”**

*Response to the consultation by*

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## **1. Overview**

Publication of the next steps document during the covid-19 pandemic comes at a remarkable moment. Significant shortcomings have been exposed in the NHS<sup>1</sup>, in the systems for communicable disease control and public health,<sup>2</sup> in the procurement system<sup>3</sup> and in the social care system.<sup>4</sup> The lack of hospital and ICU capacity have been major drivers of national lockdowns in March 2020 and January 2021 and the causes of severe winter pressures in previous years.

At the same time, the pandemic has demonstrated the obstacles created by market bureaucracy and heavy-handed and centralised market regulation which have developed over decades in the NHS.

The document hints at positive effects of the pandemic (paragraph 2.1) and refers in general terms to some of them (e.g., 2.72), which have played a part in “increas[ing] the appetite for statutory ‘clarity’ for ICSs and the organisations within them.” (3.8). It also recognises “the persistent complexity and fragmentation” which is rightly complained about (1.3).

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<sup>1</sup> E.g., lack staff, beds and other capacity following inadequate investment and the absence of a workforce planning strategy over many years; inadequate planning and personal protective equipment (PPE); marginalising GPs.

<sup>2</sup> E.g., devaluing local authorities and the NHS by centralising and privatising tracking, tracing and testing; spending hundreds of millions of pounds on inaccurate lateral flow tests; by-passing the established system for notifying suspected cases.

<sup>3</sup> E.g., spending billions of pounds on untendered contracts, including to companies with no track record.

<sup>4</sup> E.g., shortages of staff and PPE; high excess deaths; inappropriate discharge of hospital patients to care homes.

This is largely the product of reforms premised on competitive relations and contracting among health bodies. Finally a new anti-competition consensus appears to have emerged in NHS reform<sup>5</sup> which has found its way, though problematically, into the document.

But as David Lock QC [has said](#) in 2019: “The big picture is that you have a market system. If you do not want a market system and you want to run a public service, you need a different form of legal structure.” And this obvious truth raises fundamental questions, which the document seems to glimpse, but which it is unwilling to grasp.

Why, for example, continue to insist on running health organisations as businesses if the aim is collaboration instead of competition? How should needs-assessment and population planning be undertaken if the aim is to secure comprehensive health and social care for geographic areas? Where should they be located and on which bodies does the statutory duty of universality fall? How can major political questions surrounding resource distribution be undertaken consensually outside established political processes? Equitable access and solidarity require risk-pooling and a community response.

Rather than rising to the challenge of these questions in ways which could reliably “provide[] the right foundation for the NHS over the next decade” (page 31), the document puts forward substantial de-regulatory proposals which continue to ‘work-around’ the current statutory market-based framework and undermine risk-pooling, even when proposing legislative change; much essential detail is omitted.

As they stand, the proposals seek to achieve integration by focussing on increasing freedoms of the various bodies involved in commissioning and contracting. They rely on general exhortations to counter deregulation. Laudable “fundamental purposes” inform an “aim” of “a progressively deepening relationship between the NHS and local authorities”. Three “important observations” which may or may not be aims relate to more local decision-making, more collaboration and economies of scale. A “triple aim” duty of unspecified strength relates to “better health for the whole population, better quality care for all patients and financially sustainable services for the taxpayer” (1.3, 1.8, 1.9, 3.3).

The approach however leaves substantially unchanged the legal powers of the many incorporated bodies active in the health care market among which collaboration is expected but from which disintegration has spread. If the aim is “rebalancing the focus on competition” (3.3) a concrete

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<sup>5</sup> “These developments [of STPs and ICSs] represent an important shift in direction for NHS policy. The 2012 Act aimed to strengthen the role of competition in the NHS, consolidating a market-based approach to reform that has been in place since the establishment of the internal market in 1991. By 2019, however, competition rarely gets mentioned in NHS policy. Instead, the *Five Year Forward View*, STPs, and ICSs are based on the idea that collaboration – not competition – is essential to improve care and manage resources, including between commissioners and providers”. [Health Foundation submission](#) to the Health and Social Care Select Committee inquiry into legislative proposals in response to the NHS Long Term Plan, April 2019

administrative alternative is required. None is offered. Seeking to promote greater integration whilst retaining commercial autonomy will not work.

**In summary, the proposals:**

- leave in place the purchaser-provider split and commercial contracting;
- continue the ability to give further contracts to private companies, including, it seems, integrated care provider contracts;
- provide no response to the finding of the [National Audit Office](#) in 2017 that “The Departments have not yet established a robust evidence base to show that integration leads to better outcomes for patients”;
- favour no controls on ICS membership;
- give immense and barely-regulated power to monopoly providers and clinical networks
- contain no controls on the composition of “provider collaboratives”, which could include, for example, large private hospitals;
- are silent on public accountability mechanisms at a system level, and at the non-statutory “place” level;
- repeal section 75 of the 2012 Act, revoke some of the ‘section 75 regulations’ and remove commissioning of NHS healthcare services from the Public Contracts Regulations 2015 – which are welcome – but are silent on the safeguards against corruption and conflicts of interest, and some of the section 75 regulations would seemingly be retained;
- emphasise the importance of strategic needs assessment – which is also welcome – but do not require the assessment to frame provision or to qualify the power of providers and clinical networks;
- do not appear to make ICSs responsible for all people in an area, and there are unresolved difficulties for integrating health and social care because of different funding bases for different populations;
- are silent on whether individuals on GP lists will transfer to an ICS body, a provider or a provider collaborative;
- are unclear on the fate of CCGs in Option 2;
- contain no explanation of how capital investment strategies will operate, and whether charges on capital, including PFI charges, will change;
- do not address the powers of NHS foundation trusts;
- are unclear on how local authority public health funding will be protected;
- are unclear on how social care funding will be protected, and how the currently different funding bases for health and social services will be addressed;
- are silent about workforce planning;
- envisage, but are unclear about, moving staff between organisations, and their terms and conditions.

We discuss the details in the following two sections.

## 2. ICSs during 2021/22 and before legislation

The document seems to have two purposes: to further progress ICSs and the merger of CCGs ahead of legislation; and to explain changes to the NHSE/I's legislative proposals published in [September 2019](#).

Our understanding of what an ICS will be and do, before legislation, is set out in the Box below.

*Box: What will an ICS be and do before legislation – as far as we can make out?*

1. An ICS will not have legal form and will consist of:

- provider organisations as part of one or more undefined and self-determined “**provider collaboratives**” operating within and beyond the ICS playing “an active and strong leadership role” and being “a principal engine of transformation”(2.4, 2.31, 2.63); and
- “**place-based partnerships**”, defined by each ICS but seemingly comprising providers of primary care, community health and mental health services, social care and support, community diagnostics and urgent and emergency care – i.e., excluding secondary care, but including local authorities, Directors of Public Health and Healthwatch, and “may” include acute providers, ambulance trusts, the voluntary sector and other – undefined - partners (2.31, 1.16).

2. It will receive a “**single pot budget**” which would comprise “current CCG commissioning budgets, primary care budgets, the majority of specialised commissioning spend, the budgets for certain other directly commissioned services, central support or sustainability funding and nationally-held transformation funding that is allocated to systems” (2.40), and will decide how that budget should be delegated to local “places” within the ICS.

3. **Providers** will “agree proposals developed by [undefined and self-determined] **clinical and operational networks**” and will “implement resulting changes” including “implementing standard operating procedures to support agreed practice; designating services to ensure their sustainability; or wider service reconfiguration”; and will “shape the strategic health and care priorities for the populations they serve, and new opportunities – whether through lead provider models at place level or through fully-fledged **integrated care provider contractual models** – to determine how services are funded and delivered, and how different bodies involved in providing joined-up care work together” (2.11, 1.44).

4. The ICS will undertake more **strategic needs assessment** and planning than CCGs can do, resulting in “the organisational form of CCGs...evol[ing]” (2.62-2.63).

5. The ICS will be subject to **governance and public accountability** arrangements that are said to be “clear but flexible”, but will not be statutory. (2.28-28, 2.19)

We make a number of key points under the following headings:

### *(1) Strategic needs assessment*

(a) The emphasis on strategic needs-based assessment and planning is welcome, yet there will be no single body which has the responsibility to carry it out and no legal mandating of it. This is likely to

lead to buck-passing. Perhaps more importantly, it is also likely to lead to needs-based planning being overridden by increasingly powerful monopoly providers having pivotal influence over a single budget, and over its allocation both for non-secondary care services to undefined “places” with no statutory identity, and for secondary (and tertiary) care.

(b) Moreover, it seems highly unlikely that services provided would be based on the needs assessment, because clinical networks are expected to carry out “clinical service strategy reviews on behalf of the ICS” and “develop proposals and recommendations” which providers will agree. Indeed, “[c]linical networks and provider collaborations will drive...service change” (2.26, 2.11, 2.72). No tie-in to the strategic needs assessment is proposed, let alone a requirement for it to frame provision.

(c) Public health experts have traditionally performed the functions of needs assessment, facilitating service development and service planning. However, public health sits outside of health services and is further fragmented between local authorities and the Secretary of State (Public Health England, [to be replaced](#) by another non-statutory body, the National Institute for Health Protection) as a result of the 2012 Act.

Clinical Support Units provide information and support for commercial contracting. They are not substitutes for public health, are not integrated into CCGs or local public health departments, and do not inform strategic needs assessment and service planning.

## *(2) The single pot budget*

It appears – certainly before, and perhaps after, legislation - that ICSs will not be responsible for all people within an ICS area. That term – an ICS area - is conspicuously absent from the proposals. The CCG membership model (‘persons for whom they are responsible’) cannot be changed without legislation and so will presumably be ‘scaled-up’ to cover all the CCGs involved.

We have previously expressed<sup>6</sup> concern about how Accountable Care Organisations would have been able to integrate health and social care services because their funding would have been for a different population (GP lists versus local authority), and would not have health service funding allocated for unregistered CCG residents who might be eligible for local authority social services. This concern still applies in relation to ICSs, including provider collaboratives and place-based partnerships, both with and without legislation, and with and without integrated provider care contracts.

In addition, the bases upon which resources will be allocated to secondary (and tertiary) care and to place-based partnerships, and within those partnerships are entirely unclear. This is presumably deliberate. Already there has been a marked decrease in administrative accountability for spending, and multiple contracts and subcontracts – which will continue - make it increasingly impossible to

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<sup>6</sup> Pollock AM, Roderick P. Why we should be concerned about accountable care organisations in England’s NHS. BMJ. 2018;360:k343. [https://allysonpollock.com/?page\\_id=11](https://allysonpollock.com/?page_id=11)

‘follow the money’, let alone to assess the costs of contract administration. Detailed financial reporting to NHSE/I is obviously essential and may be provided for, but public transparency in funding as between primary care, community and mental health services, and acute, secondary and specialist care, including sub-contracting, is also essential.

### *(3) Provider collaboratives*

No control is proposed over the composition of these collaboratives. They could and presumably will consist of private as well as public providers, e.g., of mental health services, residential and nursing care, acute hospital care and pathology services. **The potential inclusion, for example, of large private hospitals, which have been contracted during the pandemic, needs to be clarified immediately.** No control is proposed over the granting of contracts to providers within these collaboratives, who may in fact be distant from and have no connection with the local community and be subject to commercially-driven mergers, acquisitions and closures that threaten patient care.<sup>7</sup>

Full integrated care provider contracts can be awarded, though there is no reference to the House of Commons Health and Social Care Committee [in June 2019](#) having “strongly recommend[ed] that legislation should rule out the option of non-statutory providers holding an ICP contract [in order to] allay fears that ICP contracts provide a vehicle for extending the scope of privatisation in the English NHS”. In September 2019, [NHSE/I acknowledged](#) this and stated that it supported the recommendation. If private companies are not likely to be awarded such contracts, then what is lost by legislating to that effect? And what prevented a clear statement to that effect being made in this document?

Neither is there any reference to the HSC Committee’s recommendation that “ICP contracts should be piloted only in a small number of local areas and subject to careful evaluation”.

### *(4) ICS membership*

There are two potential aspects in this regard.

The document proposes for legislative change Option 2 that the ICS body should be able to appoint such members to the ICS body as it deems appropriate “allowing for maximum flexibility for systems to shape their membership to suit the needs of their populations” (3.19). It seems that this will be possible *de facto* before legislation, e.g., via the unspecified provider collaboratives. This risks giving private companies influence over the allocation of NHS funding: “they are there to make money from the NHS” in the words of [Dr Graham Winyard](#) - and should not be admitted as members. Yet the document is silent on this point.

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<sup>7</sup> E.g., Care Home Professional, Terra Firma close to £160m care home sale to Barchester Healthcare, 15 November 2019, <https://www.carehomeprofessional.com/terra-firma-close-to-160m-care-home-sale-to-barchester-healthcare-report/>

As for patients, the document is silent on whether individuals on GP lists will transfer to any provider (e.g. under an integrated care provider contract), or even to a provider collaborative – or, after legislation based on Option 2, to an ICS body; and, if so, how that would be achieved and whether individuals would have any choice in the matter. In addition, will individuals be able to move from one ICS to another? And what happens, for example, if an individual is on the list of a GP (or provider or provider collaborative) within the ICS, but lives in a local authority area within another ICS and requires social care?

NHSE/I should clarify these issues as soon as possible.

#### *(5) Public accountability*

ICSs will be making major resource allocation decisions, which will often be controversial. Transparency and scrutiny will be critical. However, the document says nothing about how current public accountability requirements and mechanisms will work in an ICS context. These mechanisms are based mainly around CCGs and local authorities, but in reality these bodies will no longer be the decision-makers. Actual decision-making will be de-coupled from legal functions and the effectiveness of public accountability will be diminished in the process.

#### *(6) Competition and contracting*

Proposals to remove market competition, compulsory contracting and the commissioning of NHS healthcare services (only) from the Public Contracts Regulations 2015 – which are welcome – cannot happen without statutory change; the rights of private providers and the purchaser-provider split remain in place. The work-arounds continue.

#### *(7) Social care*

Adult social services are means-tested. Health services are not. Providers of social care and support are said to be included in place-based partnerships, but the allocation of resources to and within the partnerships is entirely unclear. There is no mention of any safeguards to prevent services which are currently free from being re-designated as social care and so subject to means-testing and possible charges.

#### *(8) Public health*

Local authority public health will fall within place-based partnerships. As for other services covered by these non-statutory partnerships, there is no mention of how protecting public health funding will be achieved in the face of the power of provider collaboratives and clinical networks operating at the level of the ICS and beyond. Representation by DPHs and other local authorities is unlikely to be enough.

### *(9) Workforce planning*

The next steps document is silent about work force planning. Lack of doctors and staff is already a serious issue after years of fragmentation, lack of investment and, appallingly, absence of a strategy: the Kings Fund [described it](#) recently as “a workforce crisis”. NHSE/I need to be clear about how attempts to improve this critical function would operate in the ICS context.

### *(10) Moving staff and their terms and conditions*

It is proposed that there should be “frictionless movement of staff across organisational boundaries” (bizarrely in the context of data and digital technology, page 20). This is capable of different meanings across a spectrum, but nothing more is said about this, nor on the terms and conditions of staff in the ICS context. Much more information should be provided.

## **3. ICSs after legislation**

There is much less information on legislative changes in the next steps document than was contained in NHSE/I’s [September 2019](#) document entitled *The NHS’s recommendations to Government and Parliament for an NHS Bill*. The next steps document lists some of those recommendations and states, oddly, “We believe these proposals still stand” (3.3, 3.4). This statement makes it unclear whether they continue to be proposals.

The next steps document proposes two options for legislation.

**Option 1** would establish the ICS as a mandatory statutory ICS Board in the form of a joint committee of NHS commissioners, providers and local authorities with an Accountable Officer, and with one CCG only per ICS footprint which would be able to delegate “many of its population health functions to providers” (page 29).

**Option 2** would set up a new statutory ICS body as an NHS body by “repurposing” CCGs, taking on their commissioning functions, plus additional duties and powers, and having “the primary duty...to secure the effective provision of health services to meet the needs of the system population, working in collaboration with partner organisations”. It would have “flexibility to make arrangements with providers through contracts or by delegating responsibility for arranging specified services to one or more providers”. It would have a board of representatives of system partners (NHS providers, primary care and local government alongside a Chair, a Chief Executive and a Chief Financial Officer as a minimum) with the ability to appoint such other members as the ICS deems appropriate “for maximum flexibility for systems to shape their membership to suit the needs of their populations” (page 30).

NHSE/I prefer Option 2.

Most of the points we have made pre-legislation continue to apply. We expand on some of those and add to them as follows:

### *(1) Major reorganisation*

It is striking that despite the apparent opportunity for primary legislation following the Queen's Speech neither Option grapples with the fundamental questions posed in the Overview above, which flow from the anti-competitive consensus (if such there be). This might be because NHSE/I wish to avoid being seen to be proposing a major reorganisation. But this is exactly what is happening, even without legislation.

In September 2019, [NHSE/I stated](#):

“The Select Committee [in July 2019] agreed that NHS commissioners and providers should be newly allowed to form joint decision-making committees on a voluntary basis, **rather than the alternative of creating Integrated Care Systems (ICS) as new statutory bodies, which would necessitate a major NHS reorganisation.**” (emphasis added)

### *(2) Competition and contracting*

No legislative changes are proposed to the purchaser-provider split. Whilst repeal of procurement rules under section 75 of the 2012 Act and removal of commissioning of NHS healthcare services (only) from the Public Contracts Regulations 2015 are welcome, the document is silent on safeguards against corruption and conflicts of interest.

It is also important to recall that in September 2019 NHSE/I stated that it would retain a number of the provisions of the NHS (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 – commonly referred to as the ‘section 75 regulations’. Of particular worry, exacerbated by the covid-19 pandemic, is retention of “the requirement to put in place arrangements to ensure that patients are offered a choice of alternative providers in certain circumstances where they will not receive treatment within maximum waiting times”. The possibility of the use of private providers in these circumstances, rather than increasing NHS capacity, is obvious.

### *(3) Fate of CCGs*

NHSE/I still seem undecided about the fate of CCGs in Option 2. Under both Options, the document states that “current CCG functions would subsequently be absorbed to become core ICS business” (2.64). Yet the document only proposes, in relation to Option 2, to replace the CCG governing body and GP membership, but for some unknown reason does not state that CCGs will be abolished, which presumably they must be, under Option 2, with no replacement.

### *(4) ICS membership*

The document proposes in Option 2 - though we are not clear why this is not a possibility in Option 1 nor *de facto* from now onwards (see section 2(4) above) – that the ICS body should be able to appoint such members as it deems appropriate. This would be a blatant undermining of the ICS as an NHS body.

In addition, as stated above (section 2(4)), it is unclear whether individuals on GP lists would be transferred to the ICS body.

#### *(5) Missing proposals*

\* Even though both Options propose primary legislation, the document contains no proposal for ICS-specific public accountability mechanisms, for abolishing the purchaser-provider split, or to give place-based partnerships a legal identity.

\* A fundamental omission is how capital investment strategies will operate and whether charges on capital will change. NHS Property Services is now charging market rent for property occupied by Trusts, CCGs and some GP premises. Foundation trusts have autonomy over the property they hold and investment decisions. However, the Private Finance Initiative has left a legacy of major debt in health services and in local authorities. There has been no public scrutiny of the impact of the covid-19 pandemic on PFI contracts, on debt repayments and on renegotiation of the exorbitant rates of interest being paid out as part of the annual payments.

\* The powers of FTs are not addressed not least the ability to generate up to half their income from outside the NHS, at a time when public capacity is reducing and waiting lists, e.g., for surgery and cancer care, are growing. Nor is it made clear whether current contracts with large private hospital chains (SPIRE et al.) are long-term and whether they will be involved in provider collaboratives.

\* In September 2019, NHSE/I recommended abolishing the prospective repeal of the power to designate NHS trusts that was enacted in the 2012 Act but never brought into force, to support the creation of integrated care providers. The next steps document only mentions this in passing (3.3). It remains unclear if this still being proposed and, if it is, the circumstances in which it could be exercised.

#### **4. Conclusion**

These proposals are incoherent, de-regulatory and unclear, and are not equal to the existential threat that is posed by the current government to the NHS as a universal, comprehensive, publicly-provided service free at the point of delivery. This has been amply demonstrated by the government's response to the covid-19 pandemic which has directed billions of pounds to private companies to provide services that should have been provided by the NHS, Public Health England and local authorities. The proposals allow this to continue and increase.

Neither can the ambition of providing a sound foundation for the next decade be sensibly addressed without considering the inevitable but uncertain changes that will be necessary post-pandemic to the public health and social care systems, and to the functions of local authorities.

The challenge now is much greater than it was in 2019, when the difficulties of getting major NHS legislation through the House of Commons was used as a reason/excuse for not proposing legislation equal to the task of taking the market out of NHS once and for all. We urge MPs who are committed

to the NHS as a public service to support scrapping the 2012 Health and Social Care Act in its entirety and to support the [NHS Reinstatement Bill](#) which would put back the government's duty to provide key services, delegated to Strategic Integrated Health Boards and Local Integrated Health Boards.

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