The lowdown

Health news and analysis to inform and empower NHS staff and campaigners

Operose accused of putting profits before patient care

An investigation by BBC's Panorama, including sending in an undercover journalist (pictured above), has found that Operose, the UK's biggest chain of GP surgeries, has let less-qualified Patient Associates (PA) see patients without adequate supervision.

There are also reports from admin staff that some correspondence has not been processed and has waited to be seen by a GP or pharmacist for up to six months.

Operose, owned by the giant US healthcare insurer Centene, built its GP surgery business through the acquisition of first The Practice plc in 2016, with 20 GP surgeries, one urgent treatment centre, and some other community ophthalmology services around England, and then London-based AT Medics in early 2021, which gave the company an additional 49 surgeries in London. The company now has over 600,000 NHS patients on its lists at 69 surgeries.

The Panorama investigation, which was shown on the BBC the evening of 13 June, sent an undercover journalist to work as a receptionist at one of the company's 51 London GP surgeries. It was at this surgery that a GP said they were short of eight doctors and the practice manager said they

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hired the less qualified PAs because they were “cheaper” than GPs.

PAs have completed a science degree and two years of postgraduate studies, rather than the 10 years of medical education and training for GPs.

A PA can see patients and support GPs in diagnosis and patient management, but is supposed to have supervision from a GP. At the Operose surgery the undercover journalist was told by PAs that they saw all sorts of patients, sometimes without any clinical supervision and that the practice treated them as equivalent to GPs.

Less qualified and less experienced

Panorama’s investigation *(pictured below)* included talking to a dozen former employees from across the Operose group, from which further evidence was gathered that PAs were doing the same job as a GP, even though they had less experience and less qualifications, but they were also earning less money and so cost Operose less to employ.

Operose’s level of GPs was found by the investigation to be much lower than average, with just over 0.6 full time equivalent GPs per 2,000 registered patients, compared to the average of 1.2 full-time GPs, whereas Operose employs six times as many PAs as the NHS average.

Panorama also uncovered evidence of problems at Operose’s centre that deals with patient-related correspondence, where Panorama was told some correspondence had been waiting to be seen by a GP or pharmacist for up to six months.

Prof Sir Sam Everington, a senior practising GP at an unconnected partner-run practice, said he was concerned for patient safety after he had reviewed the Panorama footage.

The company denies putting profit before patient care and told Panorama that it has recruited 38 GPs in the past year and is in the process of recruiting more. It also pointed out that the Care Quality Commision has rated 97% of its practices as "good" or "outstanding".

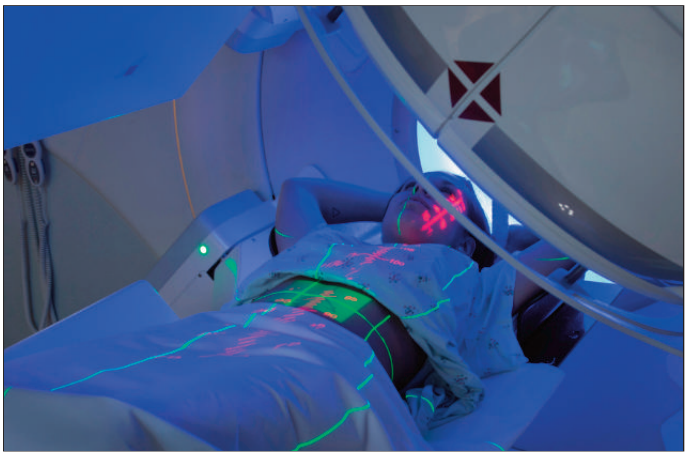
The Lowdown has been following the rise of Operose in England for a number of years. The company was formed in 2020 when the US company Centene Corporation brought its UK subsidiaries - The Practice Group (TPG) and Simplify Health - together under a single name. Separately, Centene has a 40% stake in Circle Health, the UK’s leading private hospital chain.

The company’s activity in the area of GP practices stems from its acquisition of The Practice Group in 2016. By the time of its acquisition, The Practice Group held contracts at 20 GP surgeries and ran a small number of contracts for community services, however since its beginning in 2005, the company had fared badly financially. It was also associated with a number of issues, including the employment of a high number of locums at the company’s surgeries, due to the difficulties the company had recruiting salaried GPs.

The company’s takeover of AT medics in 2021 was challenged by campaigners on the basis of lack of consultation with the public. However, the challenge was dismissed by a high court judge in February 2022.

For a full backgrounder on Operose see our page on the nhsforsale.info website

Collapse of private partner in community diagnostics hub



The private cancer diagnostic and treatment company Rutherford Health has been placed into liquidation. Only eight months ago the opening of a new community diagnostics hub (CDH) within a partnership between the company's subsidiary Rutherford Diagnostics and the NHS's Somerset Foundation Trust (SFT) was heralded as "game-changing" for the trust's capacity to carry out diagnostics.

The new stand-alone CDH, opened by Sir Mike Richards, the author of the 2020 report that pushed the idea of CDHs to expand diagnostic capacity, was part of a five year partnership deal with SFT begun in July 2020 (with the option to extend to ten years).

The centre was to provide diagnostic services including Magnetic Resonance Imaging (MRI), Computed Tomography (CT), Ultrasound and X-Ray using equipment provided by Rutherford's technology partner, Philips, in an effort to reduce the significant waiting lists for such procedures.

Rutherford Health has other contracts with the NHS - its four cancer centres treat private and NHS patients and it also holds a two-year "framework agreement" with NHS England for cancer care.

Arrangements are now being made to transfer patients to other facilities. In Somerset, Peter Lewis, Chief Executive for Somerset NHS Foundation Trust, said.

"We are looking to maintain the diagnostic centre in Taunton for our patients with minimal disruption. We will contact patients directly to reschedule their scans if this is necessary as we look to implement alternative arrangements."

The liquidation has come as a shock to employees at the company and they are now wondering how they will pay their bills at the end of the month, according to the Society of Radiographers (SOR).

A radiographer who wished to remain anonymous told the SOR that people are "devastated at the moment and really scared - we don't even get redundancy pay, we have to get statutory, so naturally everybody is really worried about bills etc especially as most hospitals have already finished their recruitment drives for the year."

The source said the mood among employees was extremely negative. "People are really angry to be honest. We had even just hired an apprentice rad a couple of months ago and nobody is having their questions answered at the moment - all the senior managers in the big Teams call this morning were acting as if we should be grateful that we have a job until Thursday, even though people have no idea how they will pay their mortgages and bills by the end of the week."

According to a statement on Monday 6 June by Rutherford's owners Schroder UK Public Private Trust, from 2015 to 2019 the company had pursued a "flawed expansion strategy" which laid the ground for an "unsustainable funding need". During this time the company opened oncology centres, known as the Rutherford Cancer Centres, in South Wales, Northumberland, Liverpool and the Thames Valley which required £240 million in capital expenditure.

Sean Sullivan, the company's interim CEO, said the pandemic had been "particularly damaging for us as fewer cancer patients have been presenting to our centres."

No option other than liquidation

The company had tried to win more contracts with the NHS but was unable to gain sufficient and this combined with "severe financial pressures on the business" following the rapid expansion meant there was no other option but to put the company into liquidation.

In January this year, Rutherford Health offered the NHS a not-for-profit three-year national contract for cancer care services, but the company said "this was not taken up".

During a visit by PM Boris Johnson to the Somerset centre in January this year, Sullivan said that he'd "explained to the Prime Minister that we were looking to support the NHS further by offering diagnostic and cancer treatment services at all of our five centres across the UK on a not-for-profit basis."

Rutherford Diagnostics has for some time planned its expansion strategy around the NHS investing significantly in private partnerships for CDHs. Back in June 2020 the company reported plans for five CDHs under a £55m agreement with "infrastructure investor and developer" Equitix. The Somerset CDH was the only one to have become reality, albeit for a brief eight months.

Sylvia Davidson

50,000 'target' unlikely to ease nursing crisis

The RCN's latest survey on workplace staffing levels in the NHS offers sobering evidence of how one of the Tories' 2019 manifesto commitments – to employ 50,000 more nurses by 2024 – has done little, if anything, to lessen the impact of nursing shortages on patient safety, or to address the reasons behind those shortages.

Among the findings of the RCN survey of its 20,000 members were the following:

– 84 per cent said staffing levels on their last shift were not sufficient to meet all the needs of patients safely and effectively

– only 25 per cent of shifts had the full number of planned registered nurses

– just one in five respondents agreed they had enough time to provide the level of care they would like, with four in five judging that patient care was compromised due to not having enough registered nurses on the shift.

– more than 40 per cent of respondents said that due to lack of time they had to leave necessary care undone

– almost two thirds of respondents worked additional time and, of these, almost eight in ten were unpaid for these additional hours.

– most shifts reported in 2022 worked with between 50 per cent and 74 per cent of the planned registered nurses, which is below the 80 per cent threshold stipulated by the RCN's nursing workforce standards

Chillingly, in a report the RCN published earlier this year it noted that, "There is a clear body of evidence that shows a direct link between nursing staffing levels and patient safety outcomes. This includes evidence that for every day that a patient is on a ward with fewer nurses than average, the chance of the patient dying increased by three per cent."

As if on cue to reinforce the RCN's messaging, news emerged earlier this month of critical problems at two major hospitals:

A nurse was filmed warning patients at an overcrowded A&E department at the Princess Alexandra hospital in Harlow that they might have to wait up to 13 hours before they were seen, because there were already 170 patients in the department, with 90 more waiting. The video was shared on Twitter by the father-in-law of one patient who, having witnessed the nurse being verbally abused by other patients, later told the Guardian, "It's a tragedy and I feel a mixture of sadness and anger. When I read of [health secretary Sajid Javid's] promise of a 'Netflix' NHS I decided it was time to drop a truth bomb on their bullshit."

Patients left unwashed

In the same week, the Care Quality Commission (CQC) warned of "significant" safety concerns at the York Hospital, run by the York and Scarborough Teaching Hospitals NHS Trust. Noting that some patients had been left unwashed for three days, the CQC echoed the results of the RCN survey, saying, "The service didn't have enough nursing staff with the right skills, training

and experience to keep patients safe and to provide the right care and treatment."

The much-hyped '50,000 by 2024' recruitment target was justifiably met with scepticism three years ago, when it was revealed that only 31,500 nurses would be newly recruited, with the balance of 18,500 made up by those already employed in the health service, and who would simply be "retained" by the NHS. The government claims that 27,000 new staff have so far been recruited under this programme.

However, in 2022 the nursing sector still has a vacancy rate of around 39,000 – equivalent to ten per cent of the workforce – and retention rates are faltering.

The number of professionals leaving the Nursing & Midwifery Council's register (ie some of the 18,500 the government is surely hoping to retain) is up, year-on-year, and one in five nursing registrants is aged 56 or older – and therefore likely to retire within the next few years, especially as pressures intensified by the pandemic take their toll on staff wellbeing.

And government statistics on nursing recruitment often fail to acknowledge an increasing and long-standing reliance on hiring from abroad to plug gaps in the domestic workforce, often to the detriment of other countries' health services. There has been a ten-fold increase since the 2019 general election in the number of nurses joining the register from countries currently identified as having the most severe workforce shortages.

Only 56 per cent of those joining the nursing register in 2021 were educated and trained in the UK, reflecting the Tories' aspiration that 12,500 of their 2019 manifesto target of 50,000 nurses were always planned to be international registrants.

Severe workforce shortage

In April new research from the King's Fund thinktank concluded that the nursing workforce shortage is set to remain severe, regardless of whether the government reaches its headline-grabbing targets, because demand is rising faster than nurses can be trained or recruited – mainly due to the growing care backlog and new targets for diagnostic and elective procedures.

Poor remuneration must surely play a part, too, hitting both recruitment and retention rates. With nurses struggling to pay their rent or afford the petrol they need to get to work, it's obvious that they need to be paid more, but the government appears determined to push through a miserly 3 per cent settlement in the latest pay review for NHS staff – despite inflation hitting 9 per cent.

This intransigence comes against a background of health service pay having stalled for more than a decade, with the TUC calculating that nurses are now £5,200 worse off compared with 2010, when pay is adjusted for inflation.

The UK already ranks below the average of high-income OECD countries in terms of both the number of practising nurses and the annual number of new nurse graduates, relative to its population. It has just under eight practising nurses per 1,000 population, while the OECD average is nine. Germany has more than 13 nurses per 1,000, while Australia has 12 and Belgium and the Netherlands each have 11.

More narrowly, in the UK, in specialisms such as community nursing, mental health nursing and learning disability nursing, the numbers are all already lower than they were in June 2010, according to the Health Foundation. And just last month Royal College of Midwives chief executive pointed up a shortage of more than 2,000 midwives in England alone.

Crucially, inadequate workforce planning may be the root cause of many problems within the NHS, but it's an issue the government seems reluctant to engage with. The Health Foundation, the King's Fund and the Nuffield Trust have lobbied long and hard on the issue, and collectively published concrete proposals three years ago which had a minimal impact on official thinking.

That leaves the health service with little more than the 2022-23 NHS Operating Framework, which merely commits NHS England to "work with systems to develop workforce plans". Last month Health Education England chief executive Dr Navina Evans told the Commons Health and Social Care Committee (HSCC) that her organisation's forthcoming 'Framework 15' will simply look at "what the population needs" and "what work needs to be done". She added, "It won't tell us exact numbers, but it will tell us how we need to think about and what will be required as a continuous, iterative process."

This flummery prompted committee chair Jeremy Hunt to counter, "I am deeply sceptical of publishing a framework – that's like saying we're going to publish an algorithm, but not an answer… Isn't it actually basically useless to publish a document on the biggest crisis facing the NHS if it doesn't give a simple answer that the public understands on whether or not we're actually training enough doctors and nurses for the future?"

Such cynicism was unsurprising – given that in February this year the government rejected HSCC's plea to alleviate the workforce crisis in the NHS by overhauling its approach to workforce planning, and later (in April) twice rejected an amendment to the forthcoming Health and Care Bill that would have forced it to publish regular, independent assessments of how many doctors and nurses the NHS actually needs.

Little wonder then that, in the same month, the RCN membership survey showed that, compared to before the pandemic, 74 per cent felt more valued by the general public, 54 per cent felt more valued by patients – but only 18 per cent said they felt more valued by the government.

Martin Shelley

Row over cuts follows NHS management review

General Messenger, who led the Royal Marines' invasion of Iraq may appear an odd choice to review NHS management, but with the ink barely dry on his new report the Health Secretary reframed its conclusions, using it to suggest a series of new management cuts, a proposal which General Messenger says was not part of his review.

The NHS Confederation welcomed the tone of the report but was bitter about the attack on managers that followed as the Health Secretary, vowed to be 'watchful of any waste or wokery', and to divert managers' salaries to treating waiting lists.

The NHS has a long history of trying to review its management, dating back to when Sainsbury's boss Roy Griffiths produced recommendations in 1983 to define the role of managers and tipped the balance of power in their direction.

The issue remains serious, with the latest patient safety scandal surrounding maternity practices at Shrewsbury and Telford hospital trust under police investigation after an independent report found that the lives of 201 babies could have been saved with better care.

How failings occur and remain hidden is a key question for any such investigation, but unlike the Francis and Ockendon reports the Messenger review does not provide analysis on these scandals, or explain the root of these problems. it focuses instead on principle and culture, producing a very simple 7 step prescription which few would disagree with. It does, though, alert to dangerous weaknesses that have become an engrained feature in parts of the NHS.

Although by no means everywhere, acceptance of discrimination, bullying, blame cultures and responsibility avoidance has almost become normalised in certain parts of the system.

Systemic failures

The report is an acknowledgement of systemic failure to train, support and value managers, of bullying and of a culture of blame that persists. It highlights the ongoing and serious problem that the NHS has with racism. A BMA report found 60% Asian and 57% Black doctors citing racism as a barrier to their career progression.

And yet the popular cry is not to improve management, but to clip bureaucrats and their pay. Messenger does not echo this line, a view that is supported by research from Kirkpatrick and Malby who have calculated that the number of administrative staff in the NHS is around 25%, with managers taking up only 2% of the workforce, and proposing that if anything the NHS is under-managed. The NHS Confederation points out that in the economy as a whole 9.5% of the workforce are managers, directors and senior officials. They too, pour scorn on the accusation that the NHS is overpaid. The chief executive of NHS England and NHS improvement who is responsible for the NHS has an annual budget of over 100 billion and the services 1.2 million staff is paid around £200,000.any increased capital investment into the England's NHS to tackle the massive £9bn backlog for maintenance – which according to therose almost 40 per cent in 2019-20, and is now almost as large as the whole of the current Department of Health & Social Care (DHSC) capital budget, and the cost of running the entire NHS estate (now around £9.7bn).

The context of this debate cannot be ignored, and two factors leap out. First, a failed, but huge reorganisation that began in 2012, distracted and created wasteful competition, and second, a decade-long squeeze on funding that left the workforce short of 100,000 staff, and a huge backlog in repairs to buildings and

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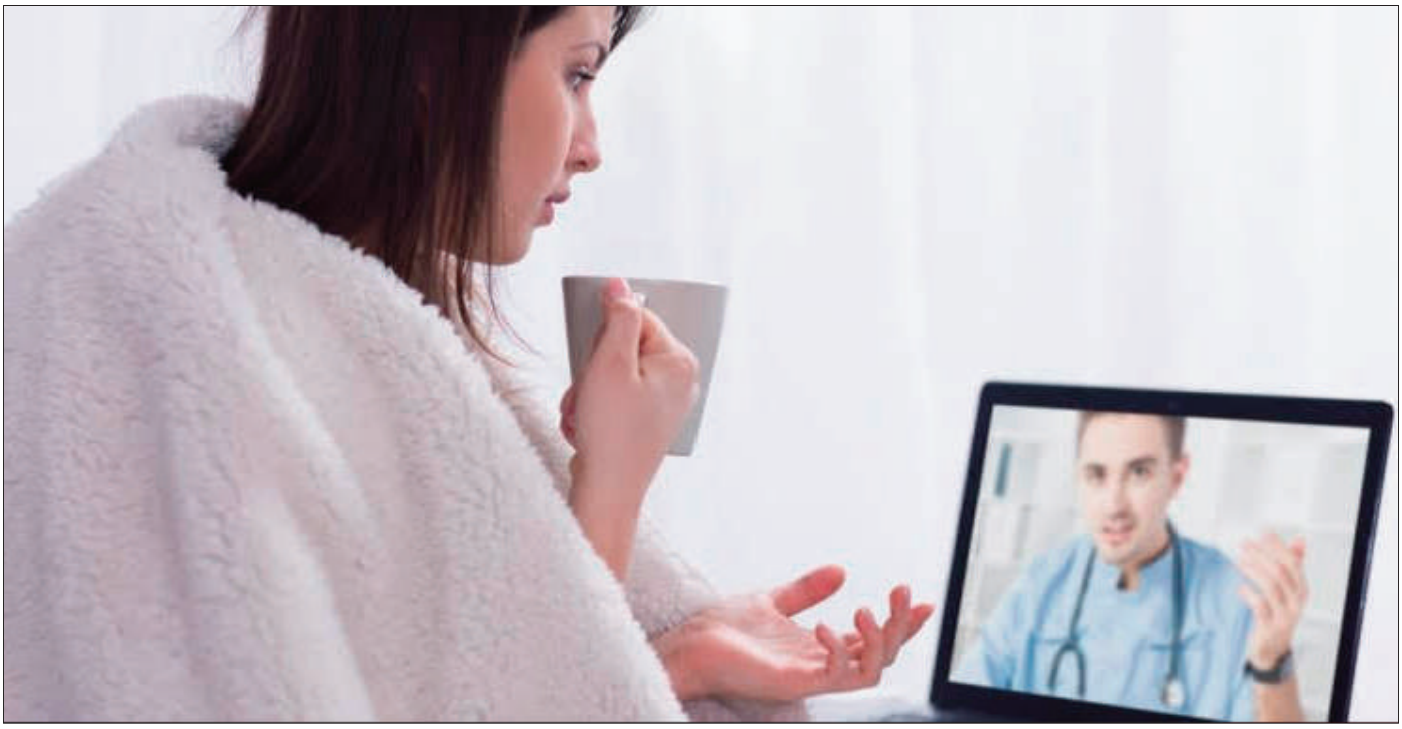

Babylon Health cautious about UK expansion

Recent comments by Babylon Health's CEO Dr Ali Parsa seem to point to the company slowing down its expansion in the UK; at a recent 'Ask The CEO' series in late May for investors, Dr Parsa said that the company needs to be "very cautious" about expanding its business in the UK as it loses money on every patient.

The issue is that the company is paid for one or two visits per year to a GP for the age cohort registered with its service, but "in reality, people use us six to seven times a year and we actually lose money on every member that comes in," noted Dr Parsa.

Dr Parsa also said the company is 'overwhelmed with demand' for GP services in the UK.

Babylon Health provides digital-first primary care services in the UK as GP at Hand and in August 2021 was the first practice in England to register more than 100,000 patients on a single list.

Rising demand for face-to-face consultations

Patients can access video consultations or see a GP in person at one of Babylon's practices in London, where more than 90% of its patients are based. The company had seven practices in London, but despite the emphasis on digital-first and video consultations, there has been a big rise in demand for face-to-face consultations, forcing the company to open two new clinics in London - the Victoria-based Dean Farrar Street clinic opened in May, and Drummond Street clinic will open in Euston in June. GP at Hand also has a clinic in Birmingham.

In the past the provider has been accused by critics of 'cherry-picking' younger, healthier patients, leaving other practices to care for patients with greater needs. Data backs up this skew to younger healthier patients, as in August 2021 almost half of its patient list were between the ages of 20 and 29, compared with 13% of the general population registered to a GP practice and 85% of the patient list was aged between 20 and 39, compared to the national proportion of 28%.

In August 2021, Babylon announced a major 10 year partnership with Royal Wolverhampton Trust, to expand the use of digital consultations. However, recent years have seen Babylon make major investments outside the UK, in particular the USA.

In 2020, Babylon launched Babylon 360 in the USA, an app-based service giving 24/7 access to healthcare and personal health goals. In late December 2021, Babylon acquired the US company Higi Holdings, a consumer health engagement company and in January 2022, Babylon Health acquired the company DaytoDay Health, based in Boston, MA. DayToDay has developed technology to support patients newly discharged from hospital and pre-op patients. The company also has investments in China, Rwanda and Canada.

New money insufficient to stop deficits and cuts

NHS England has grudgingly and belatedly come up with a promise of more money, which it claims would cover some of the inflation-driven costs faced by 42 new "Integrated Care Boards" (ICBs) which take over local health budgets from next month.

The fact that there is such money in NHS England's coffers that they were hoping to withhold makes it quite clear that the squeeze on front-line spending is a deliberate policy choice by NHS bureaucrats as well as ministers.

But of course there's a catch: the extra £1.5 billion announced at the end of last month will only be available to those ICBs who have already committed to more draconian cutbacks to balance the books, this year and next:

And even if all of this money is factored in, alongside hugely optimistic "efficiency savings," the Health Service Journal is warning ICBs will still face a combined financial gap of over £1bn this year – a substantial reversal of the £1.2bn combined surplus at the end of 2021/22, when finances were bolstered by Covid-related funding that has all been slashed back or ended since April 1.

NHSE's chief financial officer Julian Kelly has now admitted inflation – nudging close to 10 per cent – is "much higher" than the 2.8 per cent that had been assumed when plans were drawn up. He has claimed these extra costs will be handled centrally – "but, setting that aside, we need balanced plans."

Among the excess costs identified by Kelly's team, working with commissioners and providers, are an extra £485m in energy costs, £350m in care costs related to the increase in local authority-funded prices, additional costs of £150m to ambulance trusts including fuel and the financial impact of the settlement in the Flowers case on overtime and holiday pay, other pressures adding up to £405m – and a hefty £110m on Private Finance Initiative deals where payments were inflation-linked.

But to judge from The Lowdown's recent survey of finances these totals are still too low, and now the HSJ is also warning that the extra money is not enough to balance the books.

Local health chiefs have already tried every accounting trick in their efforts to reduce forecast deficits from a widely-rumoured initial £4bn total. But the Healthcare Financial Management Association reports the extra money will only be available to trusts which pledge to deliver even greater 'savings' above those already planned.

This will mean several ICBs will have little or no hope of any

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Cuts to hospital discharge programme fuel crisis

NHS England's response to the new austerity embodied in Rishi Sunak's spending review from last autumn has been to slash Hospital Discharge Programme (HDP) funding for the accelerated discharge of patients.

As a result almost every hospital trust, facing huge financial pressures this financial year, has opted to axe the additional support that many admit had helped to free up beds so that emergency and elective patients can be admitted.

The system, often branded "discharge to assess" was never perfect. Funding was introduced in March 2020: but in August new DHSC guidance to hospital trusts announced that the additional funding to support out of hospital "post discharge recovery and support services" would cease … six weeks after patients had been discharged.

"Instead of focusing efforts on creating 'virtual beds', NHSE's priority surely needs to be on freeing up existing beds"

And despite this system being widely branded as "discharge to assess" it soon became clear that it was often basically "discharge regardless." In many areas assessments were delayed – or resources were lacking to provide for the patients' assessed needs. A year later, the Association of Directors of Adult Social Services (ADASS) published a survey of almost all 152 social services councils in England, revealing a backlog of 75,000 disabled and older people waiting for help with their care and support.

Difficult conversations

But now, since April 1, even that limited support has been pulled away, creating an extra financial and service nightmare. Bath Swindon and Wiltshire

CCG has said HDP funding last year was £30m, and the loss of it has resulted in "Difficult conversations with system partners…".

Lancashire Teaching Hospitals Trust, facing a £100m deficit, now warns of the need for "a plan to right size the bed base and/or seek additional funding. … This work needs to incorporate the impact of the termination of the hospital discharge funds."

Norfolk & Waveney CCG, starting the financial year with a £50m underlying deficit, notes more than a fifth of this (£11m) is due to loss of Hospital Discharge Funding.

Hampshire and Isle of Wight CCG, forecasting a £105m deficit this year – if £159m of "efficiency savings" can be achieved – notes that the local system's finances were only balanced last year through £200m of "non-recurrent measures (Elective Recovery Funds … Hospital Discharge Programme … surge funding and non-recurrent efficiencies)".

Short-term savings, long-term problems

With trusts and commissioners facing the need for short-term savings, few feel able to look to longer term investment in the support services – community health and social care – that could free up more hospital beds and improve the quality of care for patients.

Meanwhile the most recent statistics show almost 18,000 patients had been in acute beds for more than 21 days on April 22, and 27,000 for over 14 days. NHS hospitals are becoming like the Hotel California, where "You can check-out any time you like, But you can never leave."

The result is the queues of ambulances seeking in vain to hand over emergency patients, while too many hospitals, like Salisbury, are simply silting up, with beds filled by patients who through no fault of theirs are now branded "No Criteria to Reside" (NC2R) because they have completed their treatment and care episode and are deemed able to be discharged.

Salisbury hospital has 396 beds, of which NC2R patients filled almost a third in the month of April. Its May trust Board heard "As a consequence of this the hospital has significantly reduced "patient flow" and cannot properly function as clinically intended."

Add this pressure to the 4,300 beds still taken up by Covid patients as of May 26, and the 3,000 fewer acute beds occupied in England in January-March this year compared with the same quarter prior to the pandemic, and we can see that potential NHS front-line capacity is effectively reduced by around 25,000 acute beds (25%) that cannot be used to admit emergency or elective patients, as the ambulances queue and the waiting list soars.

"Only by putting the system right can hospital trusts and West Midlands and other ambulance trusts have any confidence that they will not face the tipping point of total failure"

Instead of focusing efforts on creating so-called up to 5,000 "virtual beds," for which funding will only be available for two years, and the viability of which is in any case limited by the lack of clinical and care staff, NHS England's priority surely needs to be on freeing up existing beds, as well as reopening the beds that have been lost as a result of infection control measures and reorganisation to separate Covid patients.

This needs capital to remodel and refurbish hospital buildings, and a revenue budget that allows the restoration of HDP funding – and a real terms pay increase to attract recruits to work in the NHS at a time of relatively full employment and rampant inflation.

The stark warning over the future of ambulance services flagged up by West Midlands Ambulance trust's nursing director, as revealed in the HSJ last week, is worrying enough. Mark Docherty told the HSJ that 17 August is the day he thinks the trust's services will all fail, because if things continue to decline as they have been, "that date is when a third of our resource [will be] lost to delays, and that will mean we just can't respond."

Equally if not more worrying is the pathetically inadequate and misguided responses to this growing crisis from all those charged with leading and scrutinising the NHS, none of whom seem to realise that it's not so much a crisis of ambulance services but much more a systems failure in hospital and social care.

Only by putting the system right can hospital trusts and West Midlands and other ambulance trusts have any confidence that they will not face the tipping point of total failure.

Rishi Sunak has proved he can still access the magic money tree to help save Boris Johnson's skin and alleviate the cost of living crisis: he must be persuaded now to come up with the cash to save the NHS.

John Lister's new book with Jacky Davis NHS Under Siege, The Fight to Save it in the Age of Covid is published by Merlin Press. A 25% discount is available until July 17 for orders using the code NHS1948 at checkout via the online web page.

John Lister

Integrated Care Systems – Q&A

WHAT IS MEANT BY 'INTEGRATED CARE'?

Integrated care is a concept which encourages organisations to work together under a single plan. It can involve sharing budgets and merging functions, but it is not a new concept and many countries have been experimenting with it in their healthcare systems.

The plan for England is the integration of healthcare and social care organisations in order to provide a more efficient way of providing services.

There are numerous organisations involved that will have to work together. Within the NHS there are GPs, ambulance services, hospital services, and community healthcare, which will now have to work with social care and local authorities. The development of integrated care will have to involve integration within the health service itself and integration between health and social care.

Integration will also have to work with different forms of fund-

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ing. The NHS services are generally free at the point of use and funded by taxation, whereas social care services are often means tested with considerable input from the individual.

This Q&A deals with England, however there are changes ongoing in Scotland, Wales and Northern Ireland. In Scotland plans are underway to establish a National Care Service that would see changes to transfer existing Integration Authorities into new Community Health and Social Care Boards. Changes are also planned in Northern Ireland and Wales to increase health and social care integration.

The NHS has been working on various forms of integration within certain geographical areas for many years. However, since the publication of the NHS ten-year long-term plan in January 2019, the development of integrated care has become a top priority.

HOW ARE THE ICSs ORGANISED?

By April 2021, England had been divided into 42 Integrated Care Systems (ICS). These are areas of varying size and population levels.

Under the Health & Care Bill that finally became law in May 2022, ICSs will become legal entities on 1 July 2022, with the creation of two related entities for each ICS – an integrated care board (ICB) and integrated care partnership (ICP). These two bodies will lead an ICS and have responsibilities within the ICS, as follows:

Integrated Care Board (ICB): a statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the ICS area. ICBs will take over the commissioning responsibilities of clinical commissioning groups (CCGs) and these will be abolished. CCG staff are expected to transfer to the ICB.

Integrated Care Partnership (ICP): this organisation will be responsible for bringing together a wider set of organisations to promote partnership arrangements and develop a plan to address the broader health, public health and social care needs of the population. Membership of the Partnership Board will include representatives from the ICB, and others to be determined locally, such as local government, NHS organisations, social care providers, housing providers, independent sector providers, and local Healthwatch organisations. They will be responsible for developing an integrated care strategy, which sets out how the wider health needs of the local population will be met.

In addition, as ICS areas are massive, often covering over 1 million people, NHS England expects these areas to be broken down into smaller units within which providers and commissioners will integrate care. It has proposed places and neighbourhoods in its guidance on ICSs.

Place-based partnerships (populations of around 250,000 to 500,000 people): served by a set of health and care providers in a town or district, connecting PCNs (see below) to broader services, including those provided by local councils, community hospitals or voluntary organisations.

Neighbourhood/Primary Care Networks (PCNs) (populations of around 30,000 to 50,000 people): served by groups of GP practices working with NHS community services, social care and other providers.

There is a considerable amount of variation in the terminology used within an ICS for these partnerships within the smaller areas of the ICS.

HOW WILL PROVIDERS WORK WITHIN ICSs?

NHS Providers are expected to join provider collaboratives. These will vary in their scale and scope.

Provider collaboratives can be 'vertical' collaboratives involving local acute, primary, community, social care and mental health providers, while others could be 'horizontal' collaboratives involving providers working together across a wide geography with other similar organisations.

All NHS providers will need to join a provider collaborative, and individual providers may be involved in more than one.

Private providers will be expected to be part of provider collaboratives, but after much campaigning, no private company will be allowed to have a representative seat on an ICS board.

The model of care provision in an ICS could involve an integrated care provider contract (ICPC), under which there will be a contract with a single organisation for the majority of health and care services in the area. The ICPC holder would be responsible for the provision of services, but may not necessarily deliver all the services itself. It could instead hold sub-contracts with other providers.

WHAT LEGISLATION WAS NEEDED FOR ICSs?

In February 2021, the Department of Health and Social Care published the White Paper Integration and innovation: working together to improve health and social care for all, which sets out legislative proposals for a health and care bill. The white paper contained proposals to get rid of the competition rules introduced in the 2012 Health & Social Care Bill which led to an increase in outsourcing.

The proposals also include a range of measures intended to support integration and collaboration. At the heart of the changes was a proposal to establish ICSs as statutory bodies in all parts of England.

In May 2022 the Health & Care Bill had progressed through Parliament, with some amendments, and was given royal assent. ICSs will become statutory bodies from 1 July 2022.

HOW WELL DEVELOPED ARE ICSs?

Prior to the Government's Health and Care Act passed in May 2022, ICSs had been developing in an informal way based on alliances. Despite statutory status beginning 1 July 2022, it is still unclear just how much integration has actually taken place.

Recruitment of chief executives for Integrated Care Boards (ICBs) has been slow and difficult. By December 2021 all ICS had announced their CEOs and six had confirmed that they had failed to find one.

In May 2022, an investigation by the HSJ found that most ICS had not appointed a procurement lead despite NHS England directing the new local bodies to have a dedicated director in place by April 2022. Only 12 of the 34 ICSs which responded to HSJ's survey said they had appointed a dedicated procurement lead.

WILL PRIVATE COMPANIES BE INVOLVED IN ICSs?

The simple answer is yes, but not at the level of influence that was feared at first.

When the Health & Care Bill 2022 began its passage through Parliament, campaigners highlighted the possibility of private providers having a seat on ICS boards and thus an influence over commissioning.

After vigorous campaigning by organisations and amendments tabled by the Labour Party for changes to the Health & Care Bill so that private companies could not have representatives on Integrated Care Boards, eventually in September 2021 Health Minister Edward Argar agreed to table a government amendment to the Health and Care Bill that would prevent private interests from being on any Integrated Care Board.

The final Health & Care Bill does not allow the participation of the private sector in commissioning services and the new procurement system will allow the NHS as preferred provider, and will not permit contracts to be awarded to private providers without a proper open and transparent process.

However, outside of the Health & Care Bill 2022, there has been a major push for the use of the private sector to help reduce waiting lists for both diagnostic tests and elective surgery. NHS England's 'Delivery Plan,' to enable the recovery of acute services from the after-effects of the pandemic, mentions the need for reliance on the "capacity" of the private sector extensively.

Numerous amounts of guidance, such as that on virtual wards, have been issued by NHS England reminding NHS commissioners that the private sector is there to partner with.

HOW WILL ICS FUNDING BE ORGANISED?

It was not clear in the long-term plan, published in January 2019, how funding for integrated care systems will be organised. The Covid-19 pandemic disrupted the development of ICSs as funding was increased to cope with Covid pressures.

By 2022, it was clear that funding for ICSs will be under a stricter regime than the previous two years. Each ICS has been allocated a budget and every ICS, including those that carried huge deficits going into the pandemic, will be told to deliver financial balance in 2022-23, according to draft guidance seen by HSJ.

Some ICS went into the pandemic with deficits of more than £100m, and are likely to struggle to reach a balanced position. It is unclear what the consequences will be for an ICS that fails to meet the instructions to break-even and over-spends.

WILL ICSs LEAD TO RATIONING?

In other areas of the world, Accountable Care Organisations, which are very similar to ICS, operate with a capitated or fixed annual budget that allows the providers to retain and share any savings made. If this approach is taken for ICSs, there are concerns that services will be rationed either because the budget provided is just not enough to provide all universal healthcare services or, and this is particularly pertinent if the contract holder is a private company, to produce savings to increase the amount of budget that the providers can retain as profit.

The funding allocation for each ICS was published by NHS England in early April 2022. NHS England expects every ICS, including those who went into the pandemic with huge deficits of over £100m, to deliver financial balance in 2022-23. The ICS are being asked to hit an average efficiency target of 4% and break-even, at the same time as meeting targets for boosting elective activity and diagnostics activity.

For 2022-23 it has been reported in the HSJ that there are significant gaps between allocated and projected spending.

In late April 2022, an analysis by HSJ found that every ICS has seen its core recurrent funding reduce in real terms in 2022-23. As public sector inflation is officially forecast to be 4% this year, this wipes out the 3.3% cash increase in the funding allocated to ICS. If inflation ends up higher than this, as predicted, then the funding reduction will be greater.

NHS Providers has warned that such restrictive funding means could force NHS trusts to close services in some areas and 'streamline' them to single sites. There could also be an increase in thresholds for treatment, particularly in mental health, which is effectively a way of rationing care.

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equipment. Money is not the answer to all ills in the NHS, but it is essential to any kind of realistic response to the current challenges, otherwise managers are left in perpetual crisis and systemic change is impossible.

Roy Lillee, health policy analyst and writer says that, although well crafted the report is wrongly focused on senior management and sees the NHS as "an eco-system, a complex fabric of warp and weft that gives it strength, texture and colour.

Six thousand small businesses that make up primary care. One hundred and fifty-odd, hospitals independent by statute and a plethora of community, ambulance and specialist services, each with their own world view."

Primary care and social care seem to be largely absent from the report which is a strange omission given the government's new emphasis on integrated working - which aims to bring all sides together to plan and deliver health and social care. Within primary care the number of GP partners is declining quickly, so there is an opportunity and need to invest in new management at the local level to help ensure the integration the government is aiming at.

Overall there has been a warm welcome to the report as it raises questions about how to support the role of management and attack longstanding problems within the service, but questions remain about the deeper analysis and the level of commitment of politicians to change - the Health Secretary's immediate populist charge, criticised and underminedmanagers at the very time that all NHS staff need our support.

Paul Evans

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additional hand-out. Worse, the funding crisis is certain to worsen the staffing crisis across the NHS.

None of the extra funding allows for increased pay to NHS staff, who are facing huge increases in the cost of living. This despite hospitals increasingly opening food banks for their staff, while charities for nurses, midwives and healthcare assistants report claims for cash help have more than doubled of numbers this year.

Ministers are still insisting this year's NHS pay increase must be no more than 3%. But with 106,000 NHS vacancies in England, including 10% of nursing posts vacant, and staff leaving for less stressful and higher paid work elsewhere, the NHS Confederation has highlighted the "knock-on effect on workforce costs," as more expensive agency staff are used.

Nonetheless Mr Kelly is adamant that no such extra spending is allowed: "Systems will be required to agree to a number of conditions in return for the additional funding, including reasserting controls over agency and bank spending, and consultancy costs."Rishi Sunak's tight-fisted spending review has plunged the NHS into a new decade of austerity after the brutal decade from 2010.

And while NHS England seems determined to live in denial of the scale of the crisis this has created, NHS trusts and the new ICBs will not have that luxury – and face more grim years of penny-pinching and cutbacks while ministers boast of "record levels of spending".

John Lister

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