West Yorkshire and Harrogate
Health and Care Partnership

Partnership Board meeting - 3 December 2019
Response to questions from members of the public

Introductory comments to questions 1 and 2

When you make your comments on the draft Local Industrial Strategy, please will Board members bear in mind the following two points?

First, in relation to the Local Industrial Stategy's focus on Artificial Intelligence and Data, the recently-leaked documents from the UK-US Trade and Investment Working Group show that the USA is pushing for weakened data privacy rules after Brexit to give American companies access to millions of NHS patients' health records, And the UK seems alarmingly willing to play ball. Second, economic growth - a key goal of the Local Industrial Strategy - is incompatible with climate change mitigation AND health.

Question 1 - Follow the money: who really benefits from the focus on Artificial Intelligence and Data?

Since the launch of the May government's Future Funding Settlement for the NHS, which set the template for the NHS Long Term Plan, we have warned 2 that their focus was more about creating wealth for digital technology and life sciences companies, post-Brexit, than the needs of NHS patients and clinical staff:

"...what Ernst and Young calls capturing value from the human body as data platform...is the facebook model of healthcare, where an apparently free service is monetised by capturing users' data.

In pursuit of this goal, the NHS is being being redisorganised into a testbed for life sciences and digital technology corporations' "disruptive innovations".

Post-Brexit, the government's aim is to export these disruptive innovations to China, India, Saudi Arabia, Africa…, leaving NHS patients stranded high and dry with a rump service, while the huge wealth of 70 years of millions of patients' confidential medical data is mined for the profit of life sciences and digitech companies."

Now the leaked UK-USA free trade talks documents 3 strongly suggest that this is indeed the case. And that quite apart from patients' data privacy issues,

"Any planned changes to how our current data regulations operate has [sic] implications for privacy but also for the affordability of a high-quality NHS, as the service could be obliged to buy back medical technologies and expertise from overseas at high cost, even where these were created using freely exported NHS data." (Open Democracy article 1)

Q1. Response

The Partnership is unable to comment on speculation about the impact of potential future trade deals with the US.

Question 2. Economic growth is incompatible with climate change mitigation AND with health

It seems that the whole aim of the Local Industrial Strategy is to enable the Local Economic Partnership and Combined Authority to "draw down any future local growth funding (or Shared Prosperity Funding)."

But economic growth is not a sustainable or salutogenic objective. This is because so far no one has found a way to decarbonise economic activity.

And where decarbonisation processes have been identified, such as electric vehicles, these still depend on highly damaging and polluting mineral extraction that not only destroys the natural environment and harms people's health, but destabilises the politics and society of the countries concerned.

This means "clean growth" - one of the government's "challenges" that the Local Industrial Strategy commits to "making a contribution to meeting"- is a contradiction in terms.

We are familiar with blood diamonds. We should perhaps start thinking about blood decarbonisation. There are good grounds for thinking that the recent coup in Bolivia was about securing American corporate access to Bolivian lithium - the key mineral needed for the production of electric vehicles.

It's no use trumpeting allegedly salutenogenic policies for West Yorkshire and Harrogate if these policies are damaging the natural environment, killing people and ruining children's lives elsewhere. In the Democratic Republic of Congo, the extraction of cobalt needed for smart phones - which are key to the Local Industrial Strategy's focus on Artificial Intelligence and Data - is damaging the health of local people and their natural environment. As well as exploiting child labour.

We need a Local Industrial Strategy for a "one planet" economy. At the moment, if everyone in the world lived like we do, we would need 3 planets. We can't go on organising our economy based on the pursuit of economic growth.

If it is serious about climate change mitigation, rather than just greenwashing, the Local Industrial Strategy needs to work out a degrowth strategy based on a fairer distribution of wealth.

Fairer distribution of wealth is key to increasing income equality and reducing social and health injustice and inequality. We are the sixth biggest economy in the world. We don't need to grow our economy, we need to distribute its fruits more fairly. In the end, that requires legislation and regulation at the level of national government. Any salutogenic local industrial strategy should surely acknowledge and demand that.

The Local Industrial Strategy should require that all developments should comply with the principles and practices of a zero waste/closed loop economy. And that anything that promotes economic growth that worsens climate change should be ruled out.

Q2. Response

The Leeds City Region Local Enterprise Partnership has made it clear throughout the development of the Local Industrial Strategy that it is not about growth 'at any cost' and the principles of inclusive growth and clean growth are embedded throughout the draft strategy.

The City Region has agreed an ambitious agenda to respond to the climate emergency, including the aim to be UK's first zero-carbon city region by 2038. This will be achieved using a variety of evidence-led measures, including supporting business to reduce their usage of materials and energy, reduce their waste production, improve energy efficiency in homes and businesses to reduce overall energy consumption, investing in low carbon energy schemes – such as the District Heating Scheme (https://www.leeds-pipes.co.uk/) and investing in the transfer to electric vehicles and low emission vehicles for public transport and the public fleet.

The City Region remains committed to working with the Health Tech sector to be a good example of promoting both inclusive and clean growth and will remain cognisant of its purchasing power in relation to sustainably sourced materials globally. Read more in our joint Memorandum of Understanding here: (https://www.wyhpartnership.co.uk/news-and-blog/news/new-cross-sector-partnership-to-boost-leeds-city-region-healthtech-sector)

Improving the quality of life for everyone across Leeds City Region is fundamental to our Local Industrial Strategy. While Leeds City Region is a strong regional economy, offering the opportunity for excellent quality of life, these benefits are not shared equally. We are home to some of the most disadvantaged areas of the country and a significant number of people are excluded from the labour market, or else find it hard to find a route out of low paid, low skilled employment. The Local Industrial Strategy is an opportunity to create real, positive and sustainably delivered change for the people who live here.

You can read more about the full Local Industrial Strategy here: (https://www.the-lep.com/about-us/local-industrial-strategy/)

Question 3 – In relation to the updated '5 Year Strategy'

The aspirations including reduction in health inequalities and a stronger emphasis on the social determinants of good health within the document are welcome, however, a reduction in inequalities in relation to availability of treatments can mean a leveling down rather than a leveling up of access. For example, the WY&HHCP 'Improving Planned Care Programme' "aligns with the National programme of work on '17 Evidence Based Interventions'". The claim that criteria or thresholds for treatment are based firmly on evidence and therefore represent best practice is misleading. Some of the '17EBI' had little or no evidence base (e.g. removal of benign skin lesions) and where there was an evidence base, this was not interrogated to a standard that would be required by the National Institute of Health and Care Excellence when developing its own national guidelines. The strength of the NHSE recommendations is therefore questionable.

Although NHS England claimed that the 17EBI programme was necessary because doctors did not follow accepted evidence based guidelines, for some of the 17 interventions there was no evidence based guideline, and where there was, NHSE produced no evidence to show that doctors were ignoring them. The essence of evidence based medicine is in any case for clinicians to use their knowledge of both the science and the patient in engaging in a dialogue with individual patients about their wants and needs, and then advising accordingly (not having a course of action imposed on them by economic levers). The NHSE approach I would say was an inversion of evidence based medicine.

More worryingly, the source of variation (tackling variation = greater "equality") in frequency of interventions being performed was often to be found in treatment access policies already adopted by different CCG. When NHSE came up with strict criteria for the 17EBI, it was clear that some CCG were not offering treatment to patients who met these criteria, while others were doing more than average, and yet no CCG was expected to step up to the mark, and only a fall in activity was predicted. This is because CCG are allowed to take into account 'local factors' and why so many of them are able to ignore National Institute of Health and Care Excellence (NICE) guidance (e.g. 50% of CCG ignore NICE on cataract surgery, and 88% on IVF treatment). In reality, this can only be called rationing however much it may be made out to be 'evidence based' and therefore unchallengeable best practice.

I believe the WY&HHCP 'Improving Planned Care Programme' is aimed at restricting access to treatments in order to contain costs while presenting itself as a laudable exercise in promoting equity of access under the guise of evidence based medicine. Any thresholds for treatment that come out of the planned care programme should be scrutinised carefully, and the views of relevant clinicians must have been sought and taken into account. When criteria for treatment clearly go against NICE guidance this should also prompt a request for a detailed justification of 'why?'. Will the WY&HHCP make such commitments?

Q3. Response

The West Yorkshire and Harrogate Health and Care Partnership is committed to reducing health inequalities and to reducing inequity in access and availability of care. In implementing the NHS England Evidence Based Interventions we agreed that we would implement them as published and consistently across all places in WY&H. This meant that there was no 'levelling down' and in places where the clinical threshold for any interventions was more stringent, the threshold was raised to the appropriate level.

The NHS England Evidence Based Interventions policies were developed by NHS England in collaboration with the Academy of Medical Royal Colleges, NICE and NHS Clinical Commissioners. The policy is available at https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf and questions about the programme can be directed to england.EBInterventions@nhs.net .

The remainder of the commissioning policies and clinical thresholds that have been developed across WY&H have been led by clinicians from across the area and have been based on evidence and best practice guidance. Decisions about these policies are made by the WY&H Joint Committee of Clinical Commissioning Groups at their meeting in public. Meeting papers are published on the WY&H HCP website one week in advance, allowing for public scrutiny. To date all of the policies have been in line with NICE guidance where it is available, and any proposals to deviate from NICE guidance are most likely to be as a result of evidence published subsequent to the latest NICE guidance.

Q4 - More broadly, the 5 Year Strategy sets out how the ambitions of the NHS Long Term Plan will be achieved in West Yorkshire and Harrogate. There are, however, a number of important objections to the Long Term plan itself, and I would like to know whether the WY&HHCP agree with the following points:

Q4. Response

The Partnership was involved in the consultation on the development of the NHS Long Term Plan. Once the Plan was published in January 2019, the role of the Partnership became to achieve the ambitions of the Plan for the 2.7 million people living in West Yorkshire and Harrogate. Our responses to your questions are therefore based on our WY&H response to the Plan.

Question 4.1

The Long Term Plan adopts the plans of global health corporations, and aims to control costs by reducing access to healthcare and cutting the quality and cost of public health services. The Long Term Plan is the successor to the Five Year Forward View for the NHS, directly based on reports by the World Economic Forum, involving global healthcare corporations including US giants McKinsey & Company, UnitedHealth, and Kaiser Permanente.

Q4.1 Response

The Partnership does not aim to reduce access to healthcare or cut the quality of public health services. On the contrary, our draft five year plan sets out explicitly our ambitions to improve access to high quality services. It also sets out our ambition to make every penny in the pound count. We believe that working in partnership is the most effective way to ensure that everyone has access to high quality services that provide best value to the people we serve, and to taxpayers.

Question 4.2

The Plan moves away from a national service based on sharing the cost of ill health. The key idea of the NHS is that the cost of healthcare should be shared out across the country, funded by general taxation, so that medical care does not depend on postcode or personal circumstance. The Long Term Plan shifts the risk to a local integrated care system (ICS), responsible for the health and resources of a defined population, with a fixed local budget so that poor health in each "population" - Merseyside, Newcastle, Hackney, West Yorkshire . . . is now "their" problem.

Q4.2 Response

The NHS continues to be funded from general taxation. The Partnership is very strongly committed to ending the 'postcode lottery' and to ensuring that everyone across WY&H has access to high quality healthcare when they need it. Our draft five year plan includes amongst its 10 big ambitions clear, quantifiable commitments to reduce health inequalities and support people living in our most disadvantaged communities. Rather than increasing financial risk, our Partnership believes that by working together we are much better able to manage the financial resources available to us and to reduce the level of risk to individual organisations.

Question 4.3

The Plan aims to develop separate delivery systems, accountable for their own tightly controlled budgets. ICS are intended to evolve into Integrated Care Providers. These are simply new names for "Accountable Care Systems" and "Accountable Care Organisations" as they are known in the US. In an ICP, one organisation will hold the overall contract, decide what care will and will not be provided by the NHS, and subcontract the work to others, including private companies. An ICP might have an annual budget of around £2bn, and there is a possibility that the central contract could be awarded to a private company, or the ICP itself might eventually be sold.

Q4.3 Response

This is not the basis on which the Partnership operates. As our Memorandum of Understanding makes clear: "the Partnership is a servant of the people in West Yorkshire and Harrogate and of its member organisations. It does not replace or override the legal and regulatory frameworks that apply to our statutory NHS organisations and Councils. Instead it sits alongside and complements these frameworks, creating the foundations for closer and more formal collaboration"

Question 4.4

The Plan relies on private companies to develop Integrated Care Systems. NHS England has already designated 83 organisations to provide support services to develop ICS. Of these, 76 are private companies, of which 23 are US based, including Centene, Cerner, Deloitte, GE Healthcare, IBM, McKinsey, and Optum - the UK arm of UnitedHealth. Optum proclaims: "We are uniquely positioned to help with 15 years of experience in health system support. Combined with more than 20 years in integrated health systems in the US, we can provide the tools and expertise to help you manage risk, establish partnerships and engage patients in care."

Q4.4 Response

The Partnership does not rely on private sector companies. The vast majority of the work to develop the Partnership is done by staff from the NHS, local authorities, the wider public sector and the voluntary and community sector. Where private sector companies can offer specific skills and experience to help us develop our system, we will consider their use. Any work with the private sector is procured in accordance with public sector procurement regulations.

Question 4.5

The Plan will mean healthcare is a commodity subject to trade deals. In the US, health is a commodity, people who lack insurance can die without emergency treatment and medical bills can cause bankruptcy. As the government prepares for a trade deal with the US, and US negotiators intend to raise the prices the NHS pays for drugs, we want to protect the NHS from the global health market.

Q4.5 Response

The Partnership is unable to comment on speculation about potential future trade deals with the US.

Question 4.6

We in Leeds Keep Our NHS Public reject the Long Term Plan as it aims to disintegrate the NHS into local systems where care is rationed at the whim of those who hold the contracts. We would be pleased to hear the response by WY&HHCP to the above concerns.

Q4.6 Response

Rather than disintegrating the NHS, the whole rationale behind the Partnership is to integrate the health and care system across WY&H so that it better meets the needs of people in our area.