NHS England choose school holidays to launch consultation

A '3-month' consultation on new contracts for "Integrated Care Providers" (ICPs) was launched on August 3 by NHS England, as a clear indication that they wanted to minimise public awareness and participation. **The NHS England consultation document on the ICP contract can be accessed HERE, and the consultation on "evidence based referrals" (which ends on September 28) can be found HERE.**

For those unfamiliar with this latest new term, ICPs – which NHS England indignantly insists are **"not new types of legal entity, but rather provider organisations which have been awarded ICP contracts"** – we should note that they are the latest incarnation of the many-times rebranded "Accountable Care Organisations" first referred to in Simon Stevens' *Five Year Forward View*, and which many campaigners have argued represent a threat of 'Americanisation' of the NHS.

NHS England is at pains to insist that ICPs are completely different from the US ACOs, which are bodies run by health care providers which agree with insurers to provide a range of services for a defined local population at a fixed, cash limited fee based on the size of population (capitation). According to NHS England (Consultation document paragraph 20):

> "An ICP is ***not a new type of legal entity*** and so would not affect the commissioning structure of the NHS. An ICP would simply be the *provider organisation which is awarded a contract by commissioners for the services which are within scope*. It represents an additional option for the local NHS but is not expected to be used everywhere."

However it appears from the phrasing used by NHS England in the latest documentation that the ICP concept is actually closer than previous versions to the US ACO model, even though the words used to label it have now twice been changed to avoid this association. As NHS Providers director Miriam Deakin says in a recent HSJ article:

> "In a few years, we have seen "plans" develop into "partnerships", and an aspiration that all STPs become Integrated Care Systems taking collective responsibility for resource and performance management, and accelerating integrated care models. "

Insisting an ICP is *not a "legal entity"*, while at the same time describing it as a *'provider organisation'* leaves little doubt that the ICP would function outside any of the control and accountability mechanisms of the NHS, while the contract for ***"services which are within scope"*** is pretty obviously a cash-limited contract to deliver a defined range of services to a defined local population.

So what is the significance of the word "integration"? It's clearly a word with limited, tactical and specific significance in this context. Clearly the way it is interpreted by the NHS is a long way from the every-day understanding of the term among normal English speakers.

1) "Integration" does not mean the whole NHS system working together, since the various proposals from NHS England, including ICPs, have all been attempts to get around the 2012 legislation that consolidated the split down the centre of the NHS between

- purchasers (Clinical Commissioning Groups) holding purse strings,
- and Providers (NHS trusts, GPs and a gamut of private for-profit, non-profit and charitable/voluntary sector organisations) which have to compete for contracts.

NHS England repeatedly insist that they acknowledge this legal framework remains intact.

2) "Integration" does not mean local NHS organisations working together or singing from a single song-sheet, partly because of the same legal barriers and the willingness of private providers such as Virgin to invoke competition law where they feel they are excluded from (or lose) potential contracts.

This is clear in Ealing, where the CCG has decided to carve out a £450m (£45m-per year, 10-year) contract to provide a range of community services, which has been opened up to NHS trusts and private providers, with interest from Virgin. Whether or not the contract goes to an NHS or a private provider, the services it covers will be broken off for a decade (or until the contract collapses) from other community and health services in Ealing and the wider North West London "footprint" which had been floating ideas of "integration".

Another clear sign that there is little actual commitment to genuine integration even in areas singled out as early implementers of "integrated care systems" is that NHS trusts and CCGs which have managed to retain surpluses in their budgets have yet to commit in any area to share their surplus or in any way assist in dealing with deficits elsewhere in the locality. The latest report from NHS Providers show that just 14% of trusts have been willing to sign up for "control totals" which are supposed to set the common budget for local "Integrated Care Systems" – and only 49% of trusts agree that over time ICSs/ICPs should replace Sustainability & Transformation Plans.

3) In most areas **the alliance and "integration" that has taken place is alliances of NHS commissioners on the one side and NHS Trusts on the other.** This does not integrate the system, but provides for a more substantial conflict of interest.

4) Nor does "integration" mean any commitment by the NHS to work in partnership with local government in the provision of public health and social care: not one of the 44 Sustainability & Transformation Plans drawn up in 2016 as the basis for local areas to work towards "integration" of services contained any actual plans or commitment by NHS bodies to help address the yawning hole in local government budgets as the brutal cuts each year in central government's financial support for councils have continued since 2010.

In many areas local government leaders have made clear their concerns at finding themselves marginalised or excluded from key decisions on "integration."

5) "Integration" is clearly not even seen as the need to ensure that all staff in a given trust are employed and treated as part of the same team to develop and improve services. Amidst growing and increasingly serious shortages of medical and professional staff across the NHS, the NHS regulator NHS Improvement (which admitted in May that the service in England as a whole was operating short of almost 93,000 staff during 2017-18) blandly insisted that this was not really a problem for the safety or quality of care:

> "NHSI said the widespread lack of key staff was not putting patient safety at risk because 95% of rota gaps in nursing and 98% in medicine were filled by temporary workers."[1]

Whatever is meant by integration, one thing is clear: **the element missing from all of these scenarios has been any constructive or honest engagement or consultation with local communities potentially affected** by changes in health services and the weakening of existing accountability.

The question over the accountability of an ICP to local people revolves around the creation of an over-arching contract that effectively devolves decision-making ***from the existing CCGs***. These bodies, however imperfect, are *public bodies* required to *meet in public and publish Board Papers*, But an ICP would be a **new provider organisation**, covered by a contract that grants a very substantial degree of autonomy. As such it would have no obligations to meet in public, engage with the public, consult the public or to publish papers relating to the ICP contract.

A new democratic deficit would therefore be created – whether or not the contract goes to an "NHS" body or potentially to a private provider if one could be found willing to shoulder the risks involved for the money available.

NHS England's explanation of how an ICP would work with local commissioners fails to address any of the concerns of those who sought a judicial review to block ACOs – that the new arrangements would lack any local accountability or transparency, and would in effect take over from statutory bodies with obligations to consult and inform the public.

NHS England argues:

> "ICPs are … intended to allow health and care organisations to be funded to provide services for a local population in a coordinated way. Following two recent Judicial Reviews which were dismissed, the High Court has twice now ruled that this proposed contractual approach to developing integrated care is lawful; and in a recent report Parliament's cross-party Health and Social Care Select Committee said ICPs were part of a 'pragmatic response' to pressures in the system."

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[1] *https://www.theguardian.com/society/2018/jul/26/nhs-in-england-facing-deepening-staffing-crisis-figures-show*

Whether or not this is an explanation of the rationale behind the drive for 'Integrated Care Providers', it falls far short of committing to sustain even the limited levels of accountability that have been in place since the 2012 Act came into force.

Accountability may sound like an abstract concern: but it really matters – especially where there are increasing pressures on local commissioners and providers to reduce access to elective services in order to balance the financial books. It is significant that the consultation on the ICP runs alongside NHS England plans to restrict access to a potentially ever-expanding list of allegedly less effective treatments (see *Health Campaigns Together #11*). Already in East Sussex seven CCGs are going much further than the initial list of 17 treatments[2]:

> "Patients would have to endure "uncontrolled, intense, persistent" pain which substantially affects their daily life for six months before being routinely referred for a hip replacement, in a policy being considered by the seven CCGs in Sussex**."**

If decisions on such policies are left to ICPs with no mechanism to force them to consult, or ways in which local people can make their views and wishes felt, we could witness a drastic and rapid reduction in access to services in many parts of the country.

The public throughout England face a **concerted autumn offensive** designed to push forward plans that enjoy little if any public support, and could result in a further extension of privatisation, which nobody wants – beginning in the summer "silly season" for news with a low-profile launch of a consultation at a time while many are on holiday.

That's why it is essential to ensure that these challenges meet a response.

The following notes are an initial guide to assist local campaigners seeking to navigate the tortured language, concentrated spin and practised evasions in the 40-page ICP contract consultation document. Other guidance is expected to follow and we will share it as we receive it.

We have heard through Keep Our NHS Public that at least in some areas **NHS bodies have made clear they will disregard responses from campaign groups –** so individuals are encouraged to pick and choose which sections and questions to respond to, and to vary their wording. Campaign groups that are aware of local policy or threats to ignore their views need to publicise this far and wide as a contemptible dereliction of the duty to consult, which to be genuine must include paying attention to the concerns and views of those best-informed and most committed to the NHS and its values.

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[2] (£) https://www.hsj.co.uk/quality-and-performance/referral-restriction-plan-puts-patients-at-risk-of-opiate-addiction/7022996.article