Dr Sarah Wollaston

Chair of Health & Social Care Select Committee 25th March 2018

Dear Dr Wollaston

Re: Integrated care: organisations, partnerships and systems inquiry

1: I was pleased to receive your invitation to give oral evidence to your panel. I had assumed from your invitation that the committee wanted to hear more about the written evidence submitted by Keep Our NHS Public.

2: I have respect for you in your role as chair of the Health Select Committee, but I was surprised and disappointed at the bias exhibited in the framing of the terms of debate by yourself and some other members of the committee. The bias favoured the NHSE policy aims rather than allowing exploration of our evidence raising concerns about that policy. I felt there were constraints on what was allowed to be said – there were several challenges that I or another was not answering the question. This was not in keeping with the tradition of the select committee in ensuring independent scrutiny of government and public services.

3: I had expected to give my evidence in line with your opening words:

> 'We are going to be discussing in these hearings the desirability in policy terms, and particularly how that relates to people using services, of accountable care organisations, integrated partnerships and systems as a means of delivering care.'

4: My main observations are that:

a) The Committee refused to accept that Accountable Care Organisations had any chance of being realised in practice even though this is within stated NHSE and Department of Health policy to encourage – and part of the terms of the inquiry;
b) Argument that parliamentary debate and legislation were necessary as precursors to ACO was arbitrarily dismissed as unrealistic;
c) Linked to this was your Committee's argument that legislation is impossible. It was put to the panel, why was anybody wasting time pointed to the need for a change in the law. You took a very different approach with Simon Stevens on 20 March;
d) The context of STPs/ICSs/ACOs being explicitly financially motivated was ruled out of order;
e) The context of lack of realistic workforce plans to deliver integrated working was ruled out of order;
f) We were repeatedly asked what I, as a health professional working with other agencies for decades, regard as an insulting question on whether we supported integrated patient care.

5: I acknowledge that the Committee has already completed inquiries into NHS funding and workforce issues. I understand therefore that you did not want those issues to be explored in detail. The impact of that context however cannot be ignored.

6: Members of your committee repeatedly gave the message that Accountable Care Organisations are not going to happen. Yet when you interviewed Simon Stevens the assumption was that this was the policy direction.

7: The inquiry was to investigate STPs and ACOs. Despite recent agile renaming of policy terms (replacing the word 'accountable' with the word 'integrated' when applied to partnerships and systems), it is still the explicit policy of NHSE and the Department of Health to move towards accountable care organisations, administered by management organisations appointed through a competitive tendering process. I have read NHSE's model guidance outlining the option to invite applications from private organisations in competition with or in alliance with public sector or other private sector organisations. The special purpose vehicle used for PFI holding companies has been specified as a model to be considered.

8: You acknowledged at the outset: *'There has been recently a renaming of accountable care partnerships and accountable care systems to integrated care partnerships and integrated care systems, but the accountable care organisation model has been left with its current wording because that has been the phrasing of the consultation.'*

9: Nevertheless, your committee's attitude to our testimony implied that is was not credible because we were responding to sustainability and transformation plans and partnerships, and integrated care systems *in the context of their direction towards* ACOs. But this inquiry was into the implications of the whole policy direction and what I had to say on ICSs as precursor to ACOs was relevant.

10: NHSE and DOH policy is that ST plans lead to ST partnerships; these were pitched as more than local partners maximising their working together – they were to lead onto more formalised accountable/integrated care systems. Managerial and governance obstacles thrown up by the Health & Social Care Act are being 'worked around' by NHSE. Members of your committee were unwilling to state that these workarounds were bypassing the current law of the land. But because this ICS/ACS stage is explicitly the stage *en route to* implementing a hard-wired organisational change – with management organisations taking on the responsibility for the ACOs – the stage is set for management organisations to be operating ACOs outside of the statutory framework of the NHS – illegally – and beyond the publicly accepted governance and scrutiny it works within.

11: That this process is policy, with ICSs, or ACSs as was, progressing on to ACOs, is evident from Simon Stevens himself in:

https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

12: And guidance on contracting includes the following:

'An ACO model simplifies governance and decision making, brings together funding streams and allows a single provider organisation to make most decisions about how to allocate resources and design care for its local population. This creates a more structural solution to accountability for the care and resources for that population.'

[Page 4 Summary: Integrating care: contracting for accountable models NHS England. August 2017 https://www.england.nhs.uk/wp-content/uploads/2016/12/1693_DraftMCP-1a_A.pdf]

13: So, I have established here that the contribution I wished to make was wholly valid, and not fanciful. The risk of private companies running ACOs is real and has impact and risk. You should have allowed me and others to explain this without badgering or sarcasm from some members of the Committee. This is why I said that it was disingenuous to assume that ACOs can be set aside and to ask us to embrace parts of ICSs separate from their purpose.

14: Watching the third session and the questioning of Simon Stevens, I was struck by two things:

a) The exchange did indeed proceed on the assumption that the direction towards accountable care organisations was real.
b) Whereas members of the panel I was part of were challenged with disbelief on why primary legislation should be required for NHSE's strategy to be realised, your committee put questions to Simon Stevens inviting him to suggest what primary legislative changes would in his view be helpful.

15: I am disappointed that so much of the committee members' energy went into equating integrated patient care with NHSE's strategy to reorganise the NHS into structures with the title of integrated care systems and accountable care. I felt most clearly that I was given a closed and biased option: either to say I was in favour of ICSs (and therefore ACOs) or deny that integrated patient care was desirable.

16: There is no evidence that organisationally imposed integration delivers better care, and that is surely important for the committee in its search for evidence. We need integrated patient care but integrated organisations are not proven to be valuable – yet require dramatic widescale reorganisation to achieve. [https://www.nao.org.uk/report/health-and-social-care-integration/ National Audit Office, February 2017]

17: The truth is that ICSs and ACOs are a strategy to move away from population-based care, motivated by a severe lack in funding for health and social care (as Simon Stevens outlines in Five Year Forward View), and the end result will see health care organised by structures (ACOs) outside of current statutory legislation.

18: I should not need to repeat that integrated, coordinated care at patient level is essential, but that it requires:

a) Fully funding health and social care in both hospital, primary and community care settings;
b) A workforce strategy that is real, urgent and funded that matches the above;
c) A regained respect for health and social care professionals and managers willing to integrate delivery of services on the ground, and a listening culture that takes bottom up experience, and commits to removing barriers to such practice by governmental measures facilitating such practice: including facilitation of collaborative not competitive work; and a removal of private contracting for NHS clinical services as soon as possible.

19: I hope that the views of Keep Our NHS Public will be considered and that the Health and Social Care Select Committee will call for a halt to the move to Accountable Care Organisations, legislation to halt compulsory tendering of NHS clinical services and for a commitment that area-based delivery of health care will remain entirely within the NHS.

20: Thank you once again for inviting KONP to appear at your committee to give oral evidence with the other colleagues.

Yours sincerely

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