

KONP response submitted to Consultation on draft ICP contract (with thanks to John Lister and Louise Irvine)

Consultation questions:

1. Should local commissioners and providers have the option of a contract that promotes the integration of the full range of health, and where appropriate, care services?

No

Please explain your response.

The contract proposed does not permit genuine integration, least of all with social care which remains subject to means tested charges, is massively under-funded, and in almost every area provision is fragmented and privatised. The ICP would not be public bodies so would have no statutory legal status and no direct accountability to the public, while the CCG and Trusts would remain trapped within the confines of the 2012 Health and Social Care Act. NHS England has not taken the opportunity to give a guarantee that no services will be privatised as a result of these changes (although this is clearly a huge risk). This is a crucially important consideration since there is a very high level of risk to the health and care of hundreds of thousands of people should a privately run ICP lead provider fail.

The consultation document fails to explain why the ICP contract is required for integration. There are many areas where health and social care providers have been working in a more integrated way, despite the difficulties caused by the way health and care are organised. For example, the consultation gives Dudley as an illustration of the need for an ICP contract, but then says that integration of services in Dudley is already happening through a non contractual arrangement. If integration is already happening in Dudley, why is a new kind of contract needed? ICP do not address the root cause of poor integration, which is the competitive contract based market for health and care in England. Other impediments to integration such as understaffing, underfunding, and inadequate IT systems will not be solved by the ICP contract. Legislation to end contracting and renationalise the NHS in England is needed in order to promote genuine integration between health services. Integration between health and social care will require social care to be brought back into public provision and made free at the point of use.

2. The draft ICP Contract contains new content aimed at promoting integration. Should these specific elements be amended and if so how exactly?:

No

Please explain your response.

The ICP proposals are simply the latest of a succession of far-reaching changes being imposed upon primary care, shifting the model away from locally-based practices offering continuity of care, towards much larger, impersonal and often distant “hubs” which will break those local and personal links. NHS England needs to work with the RCGP, the BMA and other appropriate organisations to establish a new coherent policy for primary care that can enable the establishment of sustainable workloads for GPs and primary care staff, local access for patients, continuity of care for patients, and improved rapid access to services for those who need it.

As it stands, the ICP contract will be very damaging to general practice. It proposes the dissolution of general practice and its absorption into a huge organisation where patients will no longer be registered with a particular GP practice. That will undermine the personal continuing care that characterises British General Practice and which has been shown to have great benefits for patients in terms of patient quality of experience, clinical outcomes and cost effectiveness. Patients will be given no choice about whether or not their GP practice dissolves itself to join the ICP. The consultation document and draft contract fail to address the important issue of different populations and geographies for each ICP, since the ICP population is simply the list of the participating integrated or partially integrated practices. This population is not geographically based, yet the ICP is supposed to be about integrating services in a “place based” way, modelled on the CCG or local authority geographical areas.

Are there any additional requirements which should be included in the national content of the draft ICP Contract to promote integration of services?

No

Please explain your response.

As stated earlier the barriers to integration will not be overcome by a new contracting model. This is especially true of integration of health and social care. The main barrier to integration of health and social care is that health care is free and social care is means tested and charged for. This has already led to problems whereby what was previously defined as health care has been redefined as social care in order to get patients or their families to pay for care. Integration of health and social care won't be possible until entitlements to those services are aligned and both are free. That can only happen if social care is brought back into public ownership and provision.

3. The draft ICP Contract is designed to be used as a national framework, incorporating core requirements and processes. Have we struck the right balance in the draft ICP Contract between the national content setting out requirements for providers, and the content about providers' obligations to be determined by local commissioners?

 No

Please explain your response.

The consultation lacks clarity on the relationship between ICP as “lead providers” and the existing NHS providers. Neither is there clarity on the potential future involvement of private for profit providers, and no clear lines of accountability of ICP to local communities who would be dependent on the services they provide, but lack any way of influencing their decisions on allocating resources and planning services. The continued existence of the Health and Social Care Act means contracts have to be offered to the private sector as well as NHS providers: so despite assurances, there can be no guarantee that a private company will not end up in the position of “lead provider”, allegedly “integrating” services. In the current context of financial stringency, local decision making about what services to provide runs the risk of service cuts and closures. Already different STP are cutting services in different ways, and this will be exacerbated with ICP which will have an even stronger financial incentive to restrict services. This is fundamentally wrong and undermines the NHS principles of universal comprehensive care, and our rights under the NHS constitution. The consultation document says that commissioners will employ “light touch” oversight of what services the ICP is providing and how it provides them. That contradicts other statements to the effect that the commissioners will be very involved in scrutinising the ICP and its subcontractors performance and holding them to account. The public can have no confidence in a “light touch” approach to regulating such a vital, high risk contract, and it is shocking that this is even being suggested.

4. Does the bringing together of different funding streams into a single budget provide a useful flexibility for providers?

No

Please explain your response.

The single funding stream flowing through a new, unknown provider, creates huge uncertainty for existing local NHS providers. The “flexibility” given to the ICP takes the form of allowing them to make decisions with no statutory duty to consult with local communities. Regardless of the fact that technically under the law, CCG would still be responsible for the implementation of the ICP contracts, experience since the implementation of the Health and Social Care Act gives no grounds for any confidence in the willingness or ability of CCG to hold ICP to account, or to represent the interests of local people.

5 We have set out details of the ICP Contract. Do you agree or disagree with our proposal that these specific safeguards should be included?

Disagree

Please explain your response:

Fundamental criticisms of the ICP contract have already been set out in responses above. The proposals do not spell out any clear lines of democratic accountability, and there is no track record of most CCG adequately enforcing the rights and championing the needs

of local people. Since the CCG would be the arbiters of the success or failure of the ICP to comply with the contract, there can be no confidence that any of the proposed provisions would in any way constrain the ICP. There are no contractual “safeguards” that will mitigate the complete lack of transparency or accountability inherent in ICP. NHS England can’t credibly argue that creating another layer of bureaucracy and removing direct responsibility for planning and delivery of health from statutory organisations to non-statutory organisations would enhance transparency and accountability. The ICP would be able to hide behind “commercial confidentiality” to deny the public access to information. ICP may not be subject to judicial review or human rights challenges. It is also unclear what rights local government scrutiny committees would have to scrutinise the ICP and hold it to account.

Do you have any specific suggestions for additional requirements, consistent with the current legal framework, and if so what are they?

Yes

Please explain your response.

If the legal framework dictates that the only way to have better integration of care is through contracting then the legal framework has to change. Contracting should be abolished as a way of arranging health care in England. The Scottish, Welsh and Northern Irish health care systems are not based on a contracting model, it is clearly possible to plan and deliver health services without using contracting. What is needed is legislation to renationalise the NHS in England.

Consultation questions

6. Should we create a means for GPs to integrate their services with ICPs, whilst continuing to operate under their existing primary care contracts?

No

Please explain your response.

The fundamental proposition is flawed. Given that ICP are such a bad idea it would be wrong to create means for GPs to integrate with them.^[1] Better integration does not require a new kind of contract. Better integration requires resources, staff, and better IT and communication systems so that practitioners have the time and resources to provide integrated care. This applies particularly to General Practice, community services (especially District Nursing) and Social Services.

If yes, how exactly do you think we should create this?

Are there any specific features of the proposed options for GP participation in ICPs that could be improved?

No

Please explain your response.

GPs don't need a new kind of contract where their practices get disbanded and their patient lists subsumed into a huge new organisation. General Practice has demonstrated its value and effectiveness to the NHS for decades. What GPs and practice teams need is support to do their job properly, including adequate funding and staffing, protected time to take part in integrated care activities such as multidisciplinary team meetings, and better IT systems.

7. Do you think that the draft ICP Contract adequately provides for the inclusion of local authority services (public health services and social care) within a broader set of integrated health and care services?

No

Please explain your response:

This too is a misleading set of proposals. The reality is that local government has been on the outside looking in ever since they were co-opted into Sustainability and Transformation Plans in early 2016. Local government deficits in social care were cynically added in to maximise the size of the so-called "do nothing deficits" in each area, but despite the willing collaboration of too many local councils in the secretive processes of STP, not one of the STP plans when published offered any tangible support to the councils in resolving the huge and growing financial problem of seeking to maintain even the most basic statutory provision of social care as central government funding has been cut. Since the STP were published there are growing indications in many areas that local government has belatedly recognised that they were being used as fig-leaves to give a veneer of democratic involvement to undemocratic plans. More and more have become disengaged and even pulled away from local plans for "integration". Those that remain involved have done so with no clear mandate, no public support, and mainly through unelected officers, or through secretive cabinet-level links. Scrutiny bodies have failed to use their powers to scrutinise or stand up for local people. Councils adopting this approach have become useless, passive appendages to NHS initiatives. ICP offer no clear alternative to these unsatisfactory links, and do not offer any real way of integrating under-funded health care with even more seriously under-funded and heavily privatized social care, which is subject to means-tested charges.

If the aim is genuine integration, then alongside the scrapping of the 2012 Health and Social Care Act new legislation needs to reverse the privatisation of the late 1980s and 1990s to scrap means tested charges, bring home care (which used to be the public home help service) back into public ownership, along with care homes that are being run for profit, to ensure that a genuine integration can take place between the NHS and social care, as public services delivering care free at point of use and properly funded from general taxation. Health care is free and social care is means tested and charged for. This is one of the main impediments to integration of health and social care. Greater integration of health and social care, without addressing the fundamental entitlement issue, will enlarge the scope for redefining some health care as social care and facilitate

the increased transfer of funding obligations from the state to the individual. It is vital to consider any plans to integrate health and social care within the pressing context of what is happening to social care. The CQC “state of care” report in 2017 said that “the future of care for older people is one of the greatest unresolved public policy issues of our time”. The draft ICP has nothing to offer to resolve this problem. Public health is also in a grave condition. In 2012 Public Health was handed over to local authorities and immediately cut. Every year more community and public health services have been cut. It is not credible to suggest that a new kind of contract will miraculously provide resources for public health from thin air. Either the government funds public health properly or it does not. The ICP contract will make no difference to that reality.

If not, what specifically do you propose?

1. Nationalise social care as part of a national care service, fully integrated with a renationalised health service, and free at point of use, like health care.
2. Fund health and social care properly.
3. Fund public health properly.
4. Reverse the cuts to local authority funding.
5. Improve pay, working conditions and training for carers so that it becomes an attractive job where people have the time and skills to care for their clients well and feel rewarded for their dedication.

8. The draft ICP Contract includes safeguards designed to help contracting parties to ensure commissioners' statutory duties are not unlawfully delegated to an ICP. Are there any other specific safeguards we should include to help the parties to ensure commissioners' statutory duties are not unlawfully delegated to an ICP?

Yes

Please explain your response.

1. Drop the proposals for ICP.
2. Halt any further contracting out of services.
3. Keep services under the control of statutory, public bodies with established lines of accountability.
4. Revise the constitutions of CCG to create a new duty to collaborate with local NHS providers to plan and provide services pending legislation to abolish the purchaser/provider split.

It is not possible to argue convincingly that a safeguard against unlawful delegation is simply to have a phrase in the contract to say there can be no unlawful delegation. That is a circular argument. If the CCG still have the same statutory duties, but the ICP also have to carry out and support those duties, and the CCG job is to ensure the ICP fulfills those duties, there will be duplication of work, staff, bureaucracy and resources, which will increase waste, not efficiency. There will be less transparency, with confusion about lines

of accountability, and it is likely that patients and public will have little clarity about what is really going on.

9. The draft ICP Contract includes specific provisions, replicating those contained in the generic NHS Standard Contract, aimed at ensuring public accountability. Should we include much the same obligations in the ICP Contract on these matters as under the generic NHS Standard Contract?

No

Please explain your response.

As long as ICP remain bodies with no statutory legal status, there can be no guarantee they will respect any requirement to ensure public accountability. It's not clear how such a body, which would have no Board meetings in public and no board papers, could in practice "involve the public", operate an appropriate complaints procedure or comply with the 'duty of candour' obligation. The 'duty of candour' in any case only applies to things that have gone wrong, and therefore comes too late.

Even if the ICP contract has the same obligations as under the generic NHS Standard Contract the ICP's public accountability will not be direct but will be mediated through the CCG. The public will have to rely on the skills and willingness of the CCG to hold the ICP to account. Based on previous experience of poor contract management and enforcement, there is little reason for confidence that CCG would have the necessary staff, skills or willingness to rigorously and robustly manage the ICP contracts. Such a major provider of health and social care would be "too big to fail", so it is hard to see the CCG ever terminating the contract, even if performing badly. CCG will be afraid that private providers will sue them if they try to enforce the contract in a way that the provider disagrees with, or terminate the contract, as we have seen happen with Virgin.

Do you have any additional, specific suggestions to ensure current public accountability arrangements are maintained and enhanced through an ICP Contract?

Yes

Please explain your response.

The proposals for ICP should be dropped, as should any further contracting out of services. Keep services under the control of statutory, public bodies with established lines of accountability. As ICP contracts could be with non-NHS bodies they will not be subject to statutory obligations for consultation and accountability. It is the ICP concept itself that militates against public accountability. No body that is not a public statutory body can have better accountability than a public statutory body, and contract clauses cannot make up for that shortcoming. The only way to make ICP fully publicly accountable is to make them NHS public bodies.

10. It is our intention to hold ICPs to a higher standard of transparency on value,

quality and effectiveness, and to reduce inappropriate clinical variation. In order to achieve this the draft ICP Contract builds on existing NHS standards by incorporating additional provisions describing the core features of a whole population model of care and new requirements relating to financial control and transparency.

Do you think that the draft ICP Contract allows ICPs to be held to a higher standard of value, quality and effectiveness and to reduce inappropriate clinical variation?

No

Please explain your response:

The draft ICP contract particulars on quality requirements have the same quality requirements as in the NHS standard contract. These quality requirements have nothing to do with quality but are financial penalties for failure to reach certain delivery targets. The experience of the NHS standard contract is that this punitive approach to quality has failed, so there is no reason to believe it will function any better in an ICP contract. The Friends and Family test is mentioned in this context but evaluation of the test has shown it to be largely ineffective in improving quality. The ICP contract does not address education and training of health care personnel. We need a national workforce strategy, but there is no reference in the ICP contract to it having any responsibility for training the workforce within an overall national strategy.

Do you have any additional, specific suggestions to secure improved value, quality and effectiveness, and reduce inappropriate clinical variation?

Yes

Please explain your response:

Please see response above to Question 8. Accept that quality and effectiveness are not problems that can be solved by a new kind of contract and focus instead on the real causes of failings in the NHS and social care. Then, in genuine collaboration with NHS staff and patients, come up with solutions which are likely to work. If that requires extra funding, more staff, other resources, or changes to legislation then NHS England should be putting its energies into making the appropriate case to the government, not wasting its time devising new contract forms that fail to address the real issues.

11. In addition to the areas covered above, do you have any other suggestions for specific changes to the draft ICP Contract, or for avoiding, reducing or compensating for any impacts that introducing this Contract may have?

Yes

Please explain your response.

Please see response to Question 8. Abandon the ICP contract. The ICP contract is dangerous and ill conceived. It will not solve the problems it seeks to address while creating a whole new set of problems, risks and costs, including the risk of increased

privatisation. Integrated care is a worthy aim but the ICP contract is not the way to achieve it. The only way to get genuinely integrated care is through primary legislation to recreate statutory local health authorities with the power to plan and deliver services, working closely with staff and patients. Fundamentally this will require legislation to renationalise the English NHS. NHSE must make the case to government for these changes and not waste more time and resources on promoting the ICP contract.

Consultation questions

12 Are there any specific equality and health inequalities impacts not covered by our assessment that arise from the national provisions within the draft ICP Contract?

Yes

Please explain your response.

The proposals are purely tokenistic, given that the issue of equality and health inequalities are a profound weakness of STP. 31 of the 44 STP offer no proper needs analysis above a few selected statistics, and fail to show that their proposals take account of the size, state of health and locations of the population. Eleven make partial reference to needs analysis, refer to local Joint Strategic Needs Assessments, or mention other documents as the source of their local planning. Only two (Nottinghamshire and North East London) appear to take serious account of such information. Only five STP mention the issue of the potential impact of their plans on equality, and the extent to which the proposals may impact on vulnerable groups. The absence of any concern to identify and act upon local health inequalities is compounded in many STP by a failure to take account of the impact of the expanded geographical area that is covered by the Plan – ignoring the difficult issues of access to services and transport problems if services are relocated. Given that STP were promoted by NHS England as a means to improve health and tackle inequalities, this gives reason to doubt that the inclusion of a few warm words in the ICP contract would be enough to guarantee any difference of approach.

The lack of concern for inequalities arises from, or is reinforced by, the constant and still worsening financial pressures on CCG and Trusts. It won't be the wording of contracts that resolves the problem but a fresh approach to funding and the scrapping of bodies that have already shown clearly that they don't care sufficiently about the needs of the most vulnerable patients and communities. Health inequalities cannot be reduced without tackling the massive social inequalities in our society. We are one of the most unequal societies in Europe and for that reason have some of the worst health outcomes. Our children's health is among the worst in Europe. Life expectancy has plateaued for the first time in decades. Infant mortality rates are rising. The class differences in health outcomes have not shifted. Austerity is taking its toll on people's mental and physical health. Public health has been decimated. If NHSE wants to reduce health inequalities it needs to promote and lobby for policies that address the social determinants of health, in particular an end to austerity.