Suggested lines for summary answers to consultation questions

Question 1: Yes: <u>but the contract proposed is not such a contract</u>: it does not permit genuine integration, least of all with social care which remains subject to means tested charges, massively under-funded, and in almost every area provision is fragmented and privatised. The proposed ICPs would be bodies lacking defined legal status or democratic accountability, while the CCGs and trusts would remain trapped within the confines of the 2012 Health & Social Care Act.

Question 2:

a) **No:** 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.

b) **Yes:** see above responses to questions 1 and 2a.

Question 3: No: the consultation gives little clarity on the relationship between ICPs as "lead providers" and the existing NHS providers, no clarity on the potential future involvement of private for profit providers, and no clear lines of accountability of ICPs 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 & Social Care Act means contracts have to be offered to the private sector as well as NHS providers: so despite assurances, there is no guarantee that none will put a private company in the position of "lead provider" allegedly "integrating" services.

Question 4: No: the single funding stream flowing through a new, unknown provider creates huge uncertainty for existing local NHS providers. The "flexibility" given to the ICPs takes the form of allowing them to make decisions without regard to or consultation with the local communities. Regardless of the fact that technically under the law they would still be responsible for the implementation of the ICP contracts, experience since the implementation of the Health & Social Care Act from April 2013 gives no grounds for any confidence in the willingness or ability of CCGs to hold ICPs to account, or to represent the interests of local people.

Question 5:

a) **No:** 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 CCGs adequately enforcing the rights and championing the needs of local people. Since the CCGs would be the arbiters of the success or failure of the ICPs to comply with the contract, there can be no confidence that any of the proposed provisions would in any way constrain the ICPs. “Transparency” is clearly lacking from the proposed structures.

b) **No:** The answers do not lie in devising new contractual clauses for bodies which have no legal status and no accountability. The “current legal framework” is defective, and the H&SC Act and related legislation promoting contracting, privatisation and a competitive market needs to be scrapped.

Question 6:

a) No (see above responses)

c) No: the fundamental proposition is flawed.

Question 7:

a) **No.** 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 on 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 STPs, 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 STPs 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.

ICPs 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 privatised social care, which is subject to means-tested charges.

b) If the aim is genuine integration, then alongside the scrapping of the 2012 Health & 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.

Question 8: **Yes: drop the proposals for ICPs,** halt any further contracting out of services, and keep services under the control of statutory, public bodies with established lines of accountability. Revise the constitutions of CCGs to create a new duty to collaborate with local NHS providers to plan and provide services pending legislation to abolish the purchaser/provider split.

Question 9:

a) **No.** As long as ICPs remain bodies with no legal status, there can be no guarantees they will respect any requirement to ensure public accountability. It's not clear how such a body which would have no Board meeting in public, and no board papers could in practice "involve the public," operate an appropriate complaints procedure or complying with the 'duty of candour' obligation.

b) **Yes: drop the proposals for ICPs,** halt any further contracting out of services, and keep services under the control of statutory, public bodies with established lines of accountability.

Question 10:

a) **No:** see above.

b) **Yes:** see response above to Question 8.

Question 11: **Yes:** see response above to Question 8.

Question 12: **Yes**. The proposals are purely tokenistic, given that the issue of equality health inequalities are a profound weakness of STPs.

31 of the 44 STPs 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 (JSNAs), 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 STPs 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 STPs 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 STPs 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 CCGs 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.