

## **Why we are calling for the draft ICP contract to be scrapped**

NHS England is consulting on a new model of health and social care provision that could see multi billion pound contracts handed over to the private sector to provide services for areas covering up to half a million people for 10-15 years. This is called an Integrated Care Provider (ICP) contract. ICPs were previously called Accountable Care Organisations (ACOs) but the name was changed so that people would not make the connection with ACOs in the United States. ACOs in the USA have a poor record and are associated with denial of care to patients to save money.

### **ICPs present the biggest threat of NHS privatisation ever.**

And with the likelihood of the NHS being part of a post Brexit trade deal with the USA, there will be nothing to stop major US health corporations bidding for these contracts – and threatening to sue the NHS if they don't get them.

The protections in the contract against profit making companies distributing profits unless they have achieved all the performance and quality standards very much depend on the commercial contracting and accounting skills of CCGs to scrutinise and monitor companies' accounts and performance. These are skills that CCGs have demonstrated many times that they lack. We have no confidence in their ability to protect the public from profiteering by private companies.

**If NHS England really wanted to assure the public there would be no risk of a private contractor getting the contract they should insist that the contract can only go to an NHS body or other statutory provider.**

### **Abolish contracting, instead of creating new kinds of contracts**

The proposed Integrated Care Provider (ICP) contract is being sold to the public as a way of improving “integrated” health and social care.

But ICPs do not address the root cause of poor integration, which is the competitive contract based market for health and care in England. **The consultation does not explain why a new kind of contract creating a “lead provider” with multiple subcontracts solves the problems caused by contracting.** It does not offer the option of ending contracting to facilitate a more integrated health and care system. If that needs a change in the law in England then that is what should happen. The Scottish, Welsh and Northern Irish NHS do not have these problems because the 2012 Health and Social Care Act, which makes contracting virtually mandatory in England, does not apply to them. Legislation to end contracting and renationalise the NHS is needed.

### **ICPs are extremely risky**

Not only does the ICP contract open the door to still greater NHS privatisation but if an ICP provider collapses, services for thousands of people will be put at risk. This has already happened with several large lead provider contracts – Carillion is one of the worst examples where a huge “lead provider” with

multiple subcontracts, many of them with the NHS, failed, with dreadful repercussions for services, staff and buildings.

See also the catalogue of contract failures in the NHS Support Federation website (<http://www.nhsforsale.info/database/what-s-the-impact/contract-failures-2.html>).

And the Audit Commission investigation into the failure of the Uniting Care contract in Peterborough and Cambridgeshire, which cost the NHS £8.9 million: <https://www.nao.org.uk/report/investigation-into-the-collapse-of-the-unitingcare-partnership-contract-in-cambridgeshire-and-peterborough/>

### **Lack of public transparency and accountability**

Under the ICP contract local health and care services will be planned and delivered by a new organisation that may not be a public body. This would make services far less transparent and accountable to local communities. The ICP would only have a contractual “duty to engage” which is far weaker than NHS bodies’ statutory duty to consult. An ICP would not be subject to public Freedom of Information requests; not be obliged to hold its board meetings in public or make the minutes available; be able to deny the public access to information by hiding behind “commercial in confidence” protections; not be subject to judicial review. It is also unclear what rights local government scrutiny committees would have to scrutinise the ICP and hold it to account.

NHS England can’t credibly argue that creating another layer of bureaucracy and removing direct responsibility for delivery from statutory organisations, enhances transparency and accountability.

### **We don’t need ICPs to have better integration**

There are many examples across the UK of integration of services that don’t depend on contracts. NHS England seems unwilling to learn from the way that Scotland provides integrated services without contracting. In England various collaborative arrangements have been made that allow different organisations to co-ordinate care better. Interestingly the example given in the consultation document of the first potential ICP in Dudley shows health and care practitioners already working in an integrated way, in multi-disciplinary teams (MDTs). So why do they need a contract to enable this when it is already happening?

### **Ignoring the wider context: the crisis in NHS and social care**

The consultation ignores the crises in both health and social care caused by underfunding and understaffing and offers no solutions. If the ICP can’t help with these problems then what is the point of it? If social care is desperately short of funding, to the point of imminent collapse in many areas, and if health care has been starved of necessary funding increases to match population and demographic change for nearly a decade with promises of yet still inadequate funding in the future, how will bringing these together in an “integrated” way liberate adequate funding? The NAO has questioned this assumption <https://www.nao.org.uk/report/health-and-social-care-integration/>

### **Ignoring the real barriers to integration of health and social care**

Health care is free while social care is means tested and charged for. This creates a barrier to integrated care that no contract can overcome. For integration to really work social care must be properly funded and brought into public provision, free at point of use.

### **Problems with ICP whole population a annual budgets**

The fixed whole population annual budget proposed for the ICP could create perverse incentives for providers such as underbidding to get the contract. See more detail about this issue raised by the Judicial Review.

<http://999callforhhs.org.uk/999-judicial-review-aug-2018/4594401565>

If the ICP contract has the same budget as existing NHS and social care providers, which we know to be inadequate, then it seems likely they will try to “manage demand” by raising thresholds for qualifying for care, or cutting services.

### **No grounds for believing ICPs will improve public health**

The idea that the ICP contract will lead to big improvements in public health and prevention and will therefore reduce demand and costs to the health and care services is not credible. Funding for public health has been slashed and this is set to continue. Even if some of the ICP’s income is tied to public health outcomes any freedom the ICP has to divert investment and staff to public health and community services will be hard to exercise when acute services are crying out for those resources too. The ICP will not have the tools to fundamentally influence the main reasons for health inequalities, which are inequalities in the social determinants of health: poverty, low wages, poor housing and so on.

### **Unjustified claims for improved quality of care in ICP contracts**

The consultation says that the ICP will be held to higher standards of quality but the quality standards are little different from the current NHS ones. There is little evidence that fines for breaching targets or “quality incentive schemes” improve quality. Real quality improvement comes from motivated staff working together in ways that encourage and support them to do their best. The current underfunded, understaffed NHS, with overworked, demoralised and stressed out staff militates against improved quality, and no extra “quality” contract clauses in a contract will change that.

### **Fundamental changes to the nature of general practice**

The “fully integrated” version of the contract could fundamentally change the nature of general practice as experienced by the patient. Integrated GPs will have to give up their patient lists and work for the ICP. It does not look like patients will have any say in whether or not their GP does this. Patients will no longer have a GP practice they are registered with and will access any GP at any of the participating premises. This could undermine the personal, continuing care from their own GP practice that people value so highly and which has been shown to improve the patient experience, health outcomes and health care efficiency.

In summary, the ICP contract must be scrapped: it is too risky and won’t help the problems the NHS faces. Instead we need legislation to renationalise the NHS.