

**NHS England's consultation on
the contracting arrangements for Integrated Care Providers (ICPs)**

Submission by

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TO:

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Introduction

1. This submission is made by Dr Colin Hutchinson, Professors Allyson Pollock and Sue Richards, and Dr Graham Winyard. We were claimants in a recent judicial review against the Secretary of State for Health and Social Care and NHS England.¹

2. To be accurate, and fair, NHSE's bald statement that the judicial review was decided in NHSE's favour is correct insofar as clinical commissioning groups (CCGs) have the legal power to enter into the ICP contract, and that there was, at the time of the judicial review, no breach of the principles of clarity and transparency as they had not yet applied. But the judge rejected NHSE and the government's submission that the principles of clarity and transparency did not apply to health policy, and found against NHSE and the government on subsidiary points of law. This was reflected in his costs order, in view of

“the fact that (i) the Defendants changed their minds about full nationwide consultation and the use of the ACO model by early adopters; (ii) in some measure there was a degree of

¹ [Hutchinson & Anor, R \(on the application of\) v The Secretary of State for Health and Social Care & Anor](#) (Rev 1) [2018] EWHC 1698 (Admin) (05 July 2018)

confusion caused by the use by the Secretary of State of misleading language to describe the process of appointment of ACOs (designation) and as to the issue of delegation;...[and]...

The Claimants have acted in the public interest in bringing the claim and have identified some serious and important issues which will need to be considered during the course of the consultation, the substance of which will have been improved by the airing and ventilation of the Claimant's concerns and criticisms."

Overview

3. Integration of health and social care services is a laudable aim. The means of achieving it are complex and multi-faceted, and need careful consideration of statutory regimes and financial and human resources, as well as, for example, functional, organisational, cultural and relational factors. We are dismayed that the consultation documents do not present an understanding or careful consideration of this complexity.

4. We consider that contracts for Integrated Care Providers, which NHS England state "should stimulate the market", should not be introduced without new primary legislation. As proposed, they would involve systemic change, allowing for the transfer of risk and responsibility for funding, commissioning, and providing health and social services for 10, or even 15 years to one body – public or private – with the right to sub-contract entire services, and even all of them.

5. This systemic change is happening after years of NHS underfunding and when the government is ending the established local authority financing principle of 'funding follows duties'.^{2 3} It works around quite different and unaligned statutory funding and entitlement bases, and perpetuates the lack of planning resulting from the fragmentation of the NHS into autonomous provider organisations – one consequence of which is the lack of cohesive interest in contributing to the training of doctors, nurses and other staff at a time of major staff shortages.

6. There are so many risks and uncertainties associated with ICPs as currently envisaged that to introduce these multi-billion pound contracts in these circumstances without the scrutiny and authority of new primary legislation would, in our view, be cavalier and arrogant.

7. Moreover, the proposal to create ICPs as single providers of services for the population of a single CCG would result in two major health bureaucracies with responsibility for essentially the same

² Mark Sandford (2016) Public services and local government: the end of the principle of 'funding following duties', *Local Government Studies*, 42:4, 637-656, DOI: 10.1080/03003930.2016.1171753.

³ "In the period from 2010 to 2020, councils will have had to deal with £16 billion of reductions to central government grant funding. Councils in England face an overall funding gap that will exceed £5 billion by 2020...Under current Government proposals 168 councils – almost half of all English councils – will be in a position where they receive no revenue support grant (RSG) by the end of the decade", *Local Government Association Briefing, Debate on the review of the business rates system, House of Commons, Wednesday 13 June 2018*, available here:

<https://www.local.gov.uk/sites/default/files/documents/LGA%20briefing%20-%20Debate%20on%20the%20review%20of%20the%20business%20rates%20system%20-%20130618.pdf>

population. This is an absurd waste of resources that could be avoided by the re-establishment of single health authorities, reinforcing the need for primary legislation.

8. In our considered and clear view, the ICP contract should be abandoned.

9. As for the consultation, the documents play down the nature and scale of the change and indicate that NHS England (NHSE) is pressing ahead in the absence of clear and transparent explanations of certain key aspects.

10. We set out our detailed comments on those aspects in a number of questions which we consider NHSE must address and respond to before deciding to make the ICP contract available for use:

(1) Why is a contract necessary?

(2) Why would this contract promote integration for the benefit of patients?

(3) How will CCGs be able to continue to perform their statutory functions?

(4) What will happen to training and education?

(5) How will public accountability be ensured?

(6) Is the Whole Population Budget fit for purpose?

(7) How will patient choice be maintained?

(8) Why would the contract not lead to privatisation?

(9) What is the charging position under the contract?

(10) Is the contract really voluntary?

(11) What about evaluation?

11. We initially sought to make our submissions within the framework of the questions posed by NHSE. However, the points we wished to make were both within, and broader than, the questions posed. We refer to the NHSE questions where our comments fall within them.

(1) Why is a contract necessary?

12. The consultation documents do not explain why contracts are necessary. The statement that “NHS commissioners must use different contractual forms to commission primary medical services (for which GMS, PMS and APMS contracts are mandated through specific regulations and directions) and hospital and community health services (in respect of which NHS England’s Standing Rules Regulations enable us to publish, and mandate use of, the NHS Standard Contract)” implies that contracts must be used, but this would not be correct.

13. The duty of clinical commissioning groups (CCGs) and NHS England (NHSE) is to “arrange” services. This can and does include contracting, but is not synonymous with it. The consultation takes for granted that there must be a contract, and in so doing is silent about the possibility of non-contractual arrangements as alternatives.⁴

14. If NHSE is to undertake the consultation with an open mind, and satisfy the principles of clarity and transparency, then before any model ICP contract is made available for use, NHSE should provide a clear public explanation of why non-contractual arrangements cannot achieve the aim of integration.

[NHSE Question 1]

(2) Why would this contract promote integration for the benefit of patients?

15. Patients and the public need service integration, so that all of their needs are assessed and met in a holistic way. Creating a single organisation with responsibility for the whole, and giving it the right to sub-contract for the provision of all or parts of the service, provides no guaranteed promise that service integration will be the result. That will depend on shared values, collaborative approaches and relational capacity, which take time to develop. These conditions for service integration are much more likely to be developed in a coherent system based on full public accountability, rather than the shallower and more distant engagement resulting from contracts.

16. NHSE’s case for the ICP contract promoting integration is made on the basis of organisational (single provider) and financial (pooled budget) integration.

17. No explanation is given of how the organisational integration will work when the single provider would be entitled to enter into an unstated and unlimited number of sub-contracts. The fragmentation that results from the purchaser/provider split is simply being shifted and transformed into a contractor/sub-contractor split. The good examples given of how integration is happening

⁴ The Public Contracts Regulations 2015 would not apply in the absence of a contract, and section 75 of the Health and Social Care Act 2012 permits regulations to impose requirements in relation to the commissioning – not contracting - of services. The National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 do not require contracts, and can in any event readily be revoked by the Secretary of State.

now are happening where a collaborative approach to developing and delivering services occurs - in the absence of organisational integration.

18. As well as fragmentation of services, there will be fragmentation of patients. If the ICP contract proceeds, there will be no restrictions on the membership of the ICP. No information is provided about what integration means if an ICP has multiple contracts with CCGs and with the private sector, resulting in ICP patients having different levels of entitlement to services under different contracts.

19. There is little evidence that the standard NHS contract has been modified in any specific way to make it suitable for contracting social care services, and the interface between the health and care systems that have different funding streams and different entitlements to care is not acknowledged nor taken into account. No explanation is given of how financial integration will work for the benefit of patients when the ICP's funding and population would be based on GP lists which will differ from the people who live and are present in the local authority's area, and when ICPs will not have health service funding allocated for unregistered CCG residents who may be eligible under the ICP contract for local authority social services. Moreover, the consultation documents are silent on how the ICP would decide what services are health services (and so free), and social services (and so potentially charged for), and on how the ICP would be held accountable to patients and service users for those decisions. It is not an adequate answer to say that the law prevents charging for health services, particularly when the ICP would be given the right to allocate resources. Many community provided services can be deemed either health or social care. For example, considerable judgement is currently required in establishing whether people are entitled to NHS continuing healthcare funding and, in this context, decisions on what constitutes "healthcare" and what constitutes "social care" are frequently overturned on appeal. The consultation is silent on how the draft Contract might avoid such subjectivity in decisions applied broadly across the population served by an ICP.

20. The current statutory regime for integration (under s.75 of the NHS Act 2006) allows the NHS and local authorities to pool their resources, delegate functions and resources from one to the other, and enables a single provider to provide both health and local authority services, so long as the arrangements are "likely to lead to an improvement in the way in which [relevant] functions are exercised". No evidence is provided of how and why the organisational and financial integration proposed by the contract is likely to lead to improvements, and there is no acknowledgement of the National Audit Office's findings that neither central nor local government have "yet established a robust evidence base to show that integration leads to better outcomes for patients", and that "[t]here is no compelling evidence to show that integration in England leads to sustainable financial savings or reduced hospital activity."⁵

21. No evidence is provided of why the current statutory integration regime is not working. NHSE has previously stated that "the current legislative framework for pooling budgets potentially poses some challenges for the ambitions of ACOs. NHS England has developed evidence to support discussions with the Department of Health about changes to the s.75 arrangements in order to

⁵ NAO report on Health and Social Care Integration, February 2017, available here: <https://www.nao.org.uk/report/health-and-social-care-integration/>

enable the pooling of budgets for all services delivered by an ACO provider”.⁶ Yet this evidence has been neither disclosed nor explained.

22. The draft regulations published by the Department of Health and Social Care in April 2018 propose that services provided under s.75 arrangements would be ICP services.⁷ This appears to us to be seeking to transform s.75 arrangements into a new contractual form.

23. NHSE should explain why s.75 arrangements would become ICP services and why they need to be provided under a new contractual form.

[NHSE Question 2 and, in relation to local authorities, Question 7]

(3) How will CCGs be able to continue to perform their statutory functions?

24. Several statements are made to the effect that CCGs will continue to be bound by their statutory duties, and it is stated that “[t]hrough ISAP [Integrated Support and Assurance Process], NHS England and NHS Improvement will seek assurance that (amongst other things) before the contract is awarded the CCG has taken legal advice on its ability to continue to carry out its statutory functions”.

25. Taking legal advice says nothing about the substance of the advice; there appears to be no obligation on CCGs to publish it; and there is a clear risk that this might be no more than a tick box exercise.

26. Equally importantly, the consultation documents are silent on the resources and skills that CCGs will need to retain, despite Mr Justice Green’s statement in the judicial review that “[i]n particular it seems to me that the Defendants would be wise to consult on the adequacy of the provisions in the draft ACO model contract which are designed to ensure that CCGs do have adequate on-going powers of supervision, monitoring and enforcement.”

27. Indeed, the Comment Note to GC10, Monitoring Activity, states that “We have included ‘light touch’ activity monitoring provisions, on the basis that commissioners will retain an interest in activity levels notwithstanding that payment will be primarily on the basis of the WPAP.” This is a very worrying statement, not least as no explanation is given of why the monitoring provisions are less extensive than those in the NHS Standard Contract.

28. CCGs should, before entering into an ICP contract, be obliged to publish and justify in a clear, transparent and intelligible manner (1) the human and financial resources and skills, including experience levels, they currently have that enable them to carry out their statutory duties, and (2)

⁶ https://www.england.nhs.uk/wp-content/uploads/2016/12/1693_DraftMCP-6_A.pdf

⁷ See the proposed definition of an ‘integrated services provider contract’ in Regulation 3 of a new Schedule 3A (‘Suspension and reactivation of general medical services contracts’) that would be inserted into the NHS (General Medical Services Contracts) Regulations 2015 by Part 9 of the draft Amendments Relating to the Provision of Integrated Services Regulations 2018, and the same definition of the term in relation to personal medical services agreements covered in Part 10, available here: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/696900/amendments-provision-of-integrated-services-regulations.pdf

how they propose those resources and skills would change after entering into an ICP contract. This obligation should specifically cover the resources and skills relating to needs assessment, the annual commissioning plan, supervision, monitoring, enforcement, and public involvement and consultation.

[NHSE Question 8]

(4) What will happen to training and education?

29. NHSE states that requirements for training of staff will be “simplified”, that the Staff Transition and Development Programme will cover “the ICP’s plan for training, development, location and organisation of staff over time to meet the requirements of the new care model”, and that for primary medical services the ICP must comply with direction 55 which is a requirement to “co-operate” with the Secretary of State as regards his or her statutory duty in relation to education and training under section 1F of the 2006 Act and with Health Education England (HEE). We note that section 1F(2) of the 2006 Act requires “[a]ny arrangements made with a person under this Act for the provision of services as part of [the] health service must include arrangements for securing that the person co-operates with the Secretary of State in the discharge of the” section 1F duty – i.e., not simply in relation to primary medical services.

30. The paucity and focus of these proposals are striking.

31. It is not clear how training and education budgets for undergraduate and non-medical placements in secondary care and for postgraduate and medical trainees, will operate through the whole population budget. It is also unexplained how sub-contractors will be reimbursed for training and education and how that will be monitored. Moreover, the consultation is silent on how planning for training and education, and the workforce – both in terms of numbers and equitable distribution nationally – will be achieved through “simplified” requirements which focus on what is necessary for the new models of care rather than for the needs of the NHS as a system.

32. For as long as the system remains fragmented and underfunded, if ICP contracts are to be introduced they:

- should require the ICP to make a full and proportionate contribution to ensuring the future supply of fully trained clinical professionals for the needs of the NHS as a whole not the new care models; and
- should also require cooperation with the Secretary of State and HEE in relation to all services, in order to comply with section 1F(2).

[NHSE Question 11]

(5) How will public accountability be ensured?

33. There are fundamental and structural issues of public accountability that an ICP contract cannot adequately resolve without ICPs being established under primary legislation. As a result, public accountability for most if not all of health and adult social services will be degraded because in

practice it will be the ICP that is in charge. The public will be distanced from the ICP and will have to rely on the CCG to hold the ICP to account under the contract. In general it is difficult to see what real leverage the commissioner would have over a major monopoly provider. The consultation document makes great play of the remedies open to the commissioner but, for example, “the right to terminate the ICP contract” would be little more than a paper tiger when the ICP is by definition the sole provider of local services. The impotence of commissioners in the face of provider failure has been vividly highlighted by the Carillion catastrophe. We raise three detailed concerns below.

34. Firstly, it is far from clear whether the ICP would invariably be amenable to judicial review, or to a human rights or freedom of information challenge.

35. Secondly, if the ICP is an entity controlled by one or more NHS foundation trusts – such as a corporate joint venture, subsidiary or limited liability partnership - NHS Improvement would classify it as an “NHS-controlled provider”⁸ and apply different licence conditions to those imposed on NHS providers. NHS improvement estimated in September 2017 that there will be six NHS-controlled providers under the new care models over a five year period.⁹

36. One of the effects is that an ICP controlled by NHS foundation trusts would not have to provide NHS Improvement with annual reports and accounts for the purpose of the public register of foundation trusts under section 39 of the NHS Act – because the ICP would not, in law, be a foundation trust. And their forward planning documents – essential for public involvement, consultation and accountability – are, according to the Minister of State - “expected to be commercially sensitive information and held in confidence”.¹⁰ (The obligation on foundation trusts to

⁸ <https://improvement.nhs.uk/resources/oversight-nhs-controlled-providers/>

⁹ “We anticipate that some providers will wish to set up joint ventures to support the development of new care models and, in particular, to hold ACO contracts in partnership with primary care or independent sector providers. We have based our estimate on the current total of 23 PACS and MCP vanguards. Current VAT rules mean that we expect the number of providers wanting to set up a joint venture to fulfil the role of prime contractor to be low. Therefore we estimate that over the next five years approximately 10% of new care model vanguards will set up a joint venture (ie approximately two to three joint ventures), which will fall within the scope of the proposed licence condition. We estimate that a total of six providers will be affected over a five-year period.” NHS Improvement’s Consultation on our oversight of NHS-controlled providers: impact assessment, page 5, September 2017, available here:

https://improvement.nhs.uk/documents/1670/NHS_controlled_providers_impact_assessment_final.pdf

¹⁰ Written Parliamentary Q & A. NHS: Licensing. 131667. Q (Mr Dan Carden MP): To ask the Secretary of State for Health and Social Care, whether he has plans to ensure that maintenance of the rights of members of the public to (a) inspect and (b) obtain copies of the (i) annual reports, (ii) accounts and (iii) forward planning documents under section 39 of the NHS Act 2006 for entities holding new NHS-controlled provider licences. Answered by Minister of State, Stephen Barclay on 16 March 2018: “Section 39 of the National Health Service Act 2006 requires NHS Improvement (Monitor) to maintain a register of National Health Service foundation trusts including their annual accounts and reports. This section of the Act applies to foundation trusts but it neither applies to independent providers of NHS services nor will it apply to NHS controlled providers. However, under section 93 of the Health and Social Care Act 2012, NHS Improvement must maintain and publish a register of persons who hold an NHS provider licence. The names and addresses of NHS controlled providers will be included in this register. In the case of NHS controlled providers which are formed as companies or limited liability partnerships, some documents (statutory accounts and reports) will be filed annually with other regulators such as Companies House or The Office of the Regulator of Community Interest Companies.” Available here: <https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2018-03-08/131667/>

make their forward plan available to the public was abolished by section 156 of the Health and Social Care Act 2012.)

37. Another effect is a lack of transparency in relation to the governance of the ICP, as it will not be established by statute, and the level of oversight by NHS Improvement is only to be established on an ad hoc basis.¹¹

38. Thirdly, the proposed contractual provisions regarding public involvement and consultation are far from adequate, omitting mention of the commissioning plan and annual reports (ss.14Z11-15) and the duties of consultation under section 14Z13. In the relevant condition (SC14), only section 14Z2 is mentioned - expressly in SC14.2, and reflected in SC14.3. Section 14Z2 basically requires CCGs to involve people in planning of commissioning arrangements and in developing and considering proposals for changes, but the consultation duties in section 14Z13 are additional, and would be particularly critical given the transfer of so much responsibility to the ICP.

39. If NHSE decides to proceed with the ICP contract:

- NHSE should make a public statement on their view of the amenability of the different types of ICPs to judicial review, human rights and freedom of information challenges,
- ICPs controlled by foundation trusts should be under the same reporting obligations as foundation trusts, and their forward plans should be made publically available and not subject to commercial confidentiality,
- the contract should set out specifically what the ICP has to provide the CCG with in order for the CCG to carry out its public involvement and consultation duties under both section 14Z11-15, and section 14Z2, and
- the CCG's practical requirements needed to comply with ss.14Z2 and 14Z11-15 should be standing items at all Review Meetings under GC7.

[NHSE Question 9, and Questions 5 and 11]

(6) Is the Whole Population Budget fit for purpose?

40. The term Whole Population Budget is a misnomer.

41. NHSE defines it as "a budget for the whole of the population served by relevant providers, across the services in scope of the contract", but it will in fact be the aggregated sum of individual capitation budgets. Until 2013, resources were allocated to Primary Care Trusts on the basis of all residents living in a geographical area and not practice lists. PCTs allocated or contracted with providers and different funding streams for social services, primary and community services and hospital services. The switch to a rolled-up budget for all these services for each individual means

¹¹ "NHS Improvement will apply the principles of proportionality in our oversight of NHS-controlled providers. In determining the level of oversight an NHS-controlled provider will be subject to, we will consider, among other factors, the scope of the services it provides, size of turnover and whether the provider is a wholly owned subsidiary or is jointly owned by a number of providers. NHS Improvement will be clear with NHS-controlled providers at the start about the oversight to which they will be subject. This could change, however, if there are any changes to its activities."

that the provider will be allocating the budgets and making the decisions about providers and subcontractors.

42. As well as continuing questions about the legality of this payment mechanism, to be heard by the Court of Appeal,¹² we have two specific serious concerns about the WPB.

43. Firstly, it will not cover all residents in the CCG area, as it neither includes patients not registered with a GP nor residents registered with GP practices who are members of other CCGs and ICPs. It is also not known whether it will cover all residents in the local authority area if they choose to go to an out-of-area ICP. Yet the consultation is silent about these issues, which will affect patient choice, equity and social solidarity.

44. Secondly, NHSE state that a “capitated approach works by enabling risk to be more appropriately allocated to the organisation best placed to influence, manage and bear specific types of risk”. CCGs are to bear the risks of population-size and epidemiological and demographic risks. However, it has not been explained how CCGs are best placed to deal with the risks allocated to them when a key feature of the new care models is that GP providers can compete for patients. The recent experience of GP at Hand in Hammersmith and Fulham has shown how CCGs and their patient population are affected where patients rapidly switch to out-of-area GP practices and CCGs. This position will be exacerbated and affect patient choice when the whole budget is portable from one ICP to another. The consultation is silent on whether CCGs will be able to adjust the capitation budgets to reflect changing risk profiles, for example if there are large volumes of patients moving to different CCGs and ICPs; and on the associated transaction costs.

[NHSE Question 4, and Question 5 on patient choice]

(7) How will patient choice be maintained?

45. The right of any person to choose their GP was central to the NHS at its inception.¹³ NHSE states that patient choice will be maintained, and that the “draft ICP Contract has been designed to make sure that the commissioning of multiple services through a single contract does not restrict the choices people have about how and where they receive care.”

46. The provisions in the draft contract which are said to have been designed to ensure this are not, however, identified.

47. SC11 deals with the acceptance and rejection of referrals and appears to be exactly the same as in the NHS Standard Contract (save for one change for partially-integrated models). A Comment note (DS15) to SC11 however states that

¹² <https://www.crowdjustice.com/case/justice4nhs-stage5-court-of-appeal/>

¹³ “Regulations...shall include provision...for conferring a right on any person to choose, in accordance with the prescribed procedure, the medical practitioner by whom he is to be attended, subject to the consent of the practitioner and to any prescribed limit on the number of patients to be accepted by any practitioner”, NHS Act 1946, section 33(2)(b).

“The application of GC (*sic*) 11.1.2 [acceptance of referrals of individuals whose CCG/NHSE is not party to the contract where necessary to exercise legal right of choice as set out in the NHS Choice Framework], 11.1.3 [acceptance for emergency treatment where safe to do so of individuals whose CCG is not party to the contract] and 11.2 [referrals or presentations under 11.1.2 or 11.1.3 not referrals under the contract and the Who Pays? Guidance will apply] and the operation of the Non-Contract Activity rules under Who Pays? Guidance in an ICP context, are to be considered further”.

48. When the previous draft contract was issued in August 2017, SC11 was the same, and the Comment note (DS14) then stated:

“The application of GC11.1.2, 11.1.3 and 11.2 to an ACO (particularly where the ACO is a special purpose vehicle), and the operation of Non-Contract Activity rules under Who Pays? Guidance in an ACO context, are to be considered further.”

49. We have found no other reference to this ‘further consideration’, and no explanation as to why these provisions need further consideration. What is being referred to? It is crucial to maintain patient choice and any amendment to these provisions would go to the heart of the apparently unresolved questions of how patients who are enrolled with an ICP would be able to access NHS services when those services are not provided by that ICP. The absence of such information is both worrying and in our view unacceptable.

50. We are also concerned that patient choice will be affected by the adoption of a so-called ‘whole population budget’ (see our Question 6)

51. There is also another aspect of patient choice which is not addressed: what about patients who do not wish to join the ICP?

52. NHSE states that “[w]here the ICP is commissioned to provide core GP services, all permanent and temporary residents of its area will have the right to register with it.” We consider this to be a misleading statement of the proposed position, which is that GPs only have to give NHSE one month’s notice of their intention to join the ICP and under the new draft regulations issued in April 2018 (after the Department’s consultation)¹⁴ GPs would no longer be required, as originally proposed, to tell their patients of the move. That will now be NHSE’s job, after receiving the GPs’ notice, and patients “will be transferred on to the list of registered service users of the integrated services provider...unless the person decides to register with another provider of primary medical services”.

53. We consider it misleading to describe this as a right of patients to join the ICP. The position will be that patients will be automatically transferred to the ICP unless they register with a different GP, but they will not know of this until very late in the day, and nothing is said in the consultation

¹⁴ See Regulation 2 of the new Schedule 3A that would be inserted into the NHS (General Medical Services Contracts) Regulations 2015 by Part 9 of the draft Amendments Relating to the Provision of Integrated Services Regulations 2018, and the same provision in relation to personal medical services agreements covered in Part 10, available here:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/696900/amendments-provision-of-integrated-services-regulations.pdf

documents about how their choice not to join the ICP could in practice be exercised. This is highly unsatisfactory.

[NHSE Question 5]

(8) Why would the contract not lead to privatisation?

54. NHSE, the government and the Health and Social Care Select Committee have each made statements in one shape or form denying that the ICP contract will promote privatisation.

55. These statements would be credible if primary legislation clearly established ICPs as public bodies.

56. In the absence of such legislation, credibility rests on the form of the arrangement – a contractual, not a non-contractual form – and on its terms. The consultation’s silence on non-contractual forms does not support credibility. Neither does the creation of a multi-billion pound long-term contract, with up to 100% sub-contracting.

57. Little reassurance is given by the expectation that NHS bodies are first in line to use the contract, because once it is in place it is an established financial asset with a life of its own. Some credibility could be given to the statements if the ICP was prohibited from assigning the contract (i.e., passing it on), and so prevent the potential transfer of the contract in the future to a commercial company.

[NHSE Question 11]

(9) What is the charging position under the contract?

58. NHS foundation trusts are entitled to earn 49% of their income outside the NHS. They are already charging and advertising services not provided through the NHS. We also note that NHSE is currently proposing that seventeen interventions should no longer usually be provided by the NHS.¹⁵ And as services fall out of the NHS, the same can be expected of social care services especially where local authorities receive no revenue support grant.

59. Private companies can be ICPs, can be sub-contracted by ICPs, can be in joint ventures with ICPs, or can have for example insurance agreements with ICPs.

60. When the draft contract was published in August 2017, it contained a provision (GC11.25) which allowed the provider, in the provision of primary medical services, to tell service users about “other services it provides” if the information is “fair and accurate”, and these could include non-NHS services. It was not clear why this condition was needed, unless it is was to entitle the provider to

¹⁵ Evidence-Based Interventions: Consultation Document, published by NHS England, NHS Clinical Commissioners, the Academy of Medical Royal Colleges, NHS Improvement and the National Institute for Health and Care Excellence, July 2018, available here: https://www.engage.england.nhs.uk/consultation/evidence-based-interventions/user_uploads/evidence-based-interventions-consultation-document-1.pdf

inform patients of services that the provider provides outside the contract and which have to be paid for, by out of pocket expenses or insurance.

61. We note that this provision does not appear in the corresponding provisions of the draft ICP contract now being consulted on (see Fees and charging, GC11.20-21), nor does it appear in the draft Directions. However, no explanation is given for its disappearance.

62. NHSE should explain why the provision has been dropped, and whether in its view the ICP would be entitled under the contract to inform patients of services that it provides which are not covered by the contract and which have to be paid for.

(10) Is the contract really voluntary?

63. The consultation documents give the impression that the ICP contract will be voluntary. Different views might be held about this, and we are sceptical that it would be voluntary, for several reasons. One reason is that the issuing of the contract by NHSE would automatically give NHSE the legal power to mandate it.

64. This is because under Regulation 17(1)(b) of The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, NHSE has a duty to draft terms and conditions which it “considers are, or might be, appropriate for inclusion in commissioning contracts”, and is empowered under Regulation 17(2) to “draft model commissioning contracts which reflect the terms and conditions it has drafted pursuant to paragraph (1)”. Under Regulation 17(4), NHSE “may require CCGs to incorporate the terms and conditions it has drafted...in commissioning contracts that a CCG enters into”.

65. This reason for our scepticism could be remedied by NHSE, if it decides to proceed with the contract, making a clear public statement that it will in no circumstances exercise its power to mandate the contract without further public consultation.

(11) What about evaluation?

66. The need for ICPs to be established in primary legislation as NHS bodies has been accepted by the Health and Social Care Committee, but not by the government. In the report’s summary, the Committee appears to accept the need for that legislation before ICPs are introduced,¹⁶ but its recommendation only calls for that legislation if ICPs are introduced “more widely”.¹⁷ In any event,

¹⁶ “The ACO model will entail a single organisation holding a 10–15 year contract for the health and care of a large population. Given the risks that would follow any collapse of a private organisation holding such a contract and the public’s preference for the principle of a public ownership model of the NHS, we recommend that ACOs, if introduced, should be NHS bodies and established in primary legislation.” House of Commons Health and Social Care Committee. Integrated care: organisations, partnerships and systems. Seventh Report of Session 2017–19. 23 May 2018. Summary, page 5, available here: https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/650/65003.htm#_idTextAnchor000

¹⁷ “We recommend that ACOs, if a decision is made to introduce them more widely, should be established in primary legislation as NHS bodies”, paragraph 156.

subject to adherence to the requirements of a lawful consultation and to the principles of clarity and transparency, and to the need for any contract actually entered into to be lawful, NHSE appears to be pressing ahead. This (amongst other things) raises the question of evaluation.

67. According to NHSE, the first ICP is likely to be in Dudley, where it is stated that there is already “a programme of evaluation underway”, and NHSE say that they will “work with the first systems using the draft ICP Contract to ensure that:

- in the near term we capture the lessons around how to improve the local processes for designing and establishing an ICP under contract, including how amending national rules could aid this
- in the longer term there is ongoing evaluation of any improvement in population health outcomes and other measures of performance in areas served by an ICP relative to others and how these were achieved”.

68. It is difficult to over-estimate the importance of “careful evaluation” as called for by the Health and Social Care Committee – particularly as once the contract is adopted, it could be widely used long before the results of any evaluation are known.

69. No information whatsoever is provided, however, about the evaluation already underway (e.g., how was it designed? What is its methodology? How independent is it? Is baseline data already in place?); and the consultation documents are silent on what NHSE has done or is doing before the ICP contract is introduced to ensure a proper evaluation.

70. We presume NHSE will be aware that according to HM Treasury guidance for evaluation (The Magenta Book¹⁸), it should be “an objective process” and “impartial”; “the answers it provides will give an unbiased assessment of a policy’s performance”; and “[h]aving a clear idea about the questions that need to be addressed and the required type(s) of evaluation at an early stage will help inform the design of the evaluation and the expertise required”. NHSE will also be aware that health is covered by the Equalities and Human Rights Commission’s Measurement Framework.¹⁹

71. Before any decision is taken to introduce ICPs, the details of the Dudley evaluation must be disclosed; and NHSE must publish and consult on its proposed evaluation of the ICP contract and on how the proposed evaluation complies with The Magenta Book and the Measurement Framework of the Equalities and Human Rights Commission, with a view to including provisions in the ICP contract which will ensure that the data needed will be properly collected, maintained and made available for independent evaluation in accordance with the design and methodology of the evaluation process.

[NHSE Question 11]

¹⁸ <https://www.gov.uk/government/publications/the-magenta-book>

¹⁹ <https://www.equalityhumanrights.com/en/publication-download/measurement-framework-equality-and-human-rights>