

Accountable Care, Integrated Care, and Privatisation

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Integrated Care is the new name for Accountable Care, as of an NHS England document last month. I guess they want us to forget everything we knew before February 2nd, like the origins and actual history of Accountable Care. The word “integrated” sounds good – and in some contexts, like segregation in America, it was good. The word also suggests co-operation. But in the context of a £26bn cut in the annual NHS budget, and underfunded social care which is both means tested and privately provided, “integrated” is something else entirely – a shotgun marriage maybe. For this integration, both sides would need to be fully funded and social care would have to be brought into the public sector, allocated on the basis of need and free at the point of use. In the meantime, the best we can hope for is coordination, which of course is necessary right now. The Women's Hospital has to coordinate with G4S, who do the security, but they don't need to fuse with them.

The Select Committee hearings on integrated care organisations, partnerships and systems are televised, and worth watching. You can find them on parliamentlive.tv, or for Tuesday's session use tinyurl.com/y9zdngbt.

Prof. Allyson Pollock gave two reasons why formal integration of health and social care is currently impossible: There are different populations involved on each side. Local authorities serve all residents in an area, CCGs do not. They're list based. But there is competition between providers for practice lists. So the Dept of Health is funding NHS Trusts to establish GP practices, and GPs are federating. This competition for practices is because of the dissolving of practice boundaries. So it's going to be very hard to know how CCGs are going to plan and commission services when they have hundreds or tens of thousands of patients who are not actually in their area. And equally when there are tens of thousands of residents no longer eligible for services through the CCG though they're resident.

Secondly, the idea that Commissioners and Providers can agree on how to plan services comes up against the Health & Social Care Act, which means CCGs have a duty to arrange, and they're contracting for services. And providers are bidding and tendering... There is no way around this without changing the primary legislation, which Allyson Pollock, and all of us, wants to happen through the NHS Reinstatement Bill.

Tony O'Sullivan, co-chair of KONP, explained why NHS England style integration is not desirable, even if it were possible. This is another major reorganisation at a time when the NHS is very weak. The proposal is to integrate a free at the point of use health service, with a social care service that is not free at the point of use, that is means tested, that is often paid for. Real integration takes years of working together as professionals, cooperation across disciplines and agencies, it took 20 years in Lewisham to work around disabled people leaving school, or around autism. The integrated work that was mushrooming around the country post Victoria Climbié, didn't require organisational fusion, especially not with an organisation sat outside of the NHS, that's beyond FOIs and beyond public scrutiny. That's the danger. It's integration of management systems, of financial purses, and organisations, and it's at the expense of the integration of true delivery of coordinated care that's been going on and did not need Simon Stevens or Jeremy Hunt to tell us to do it.

Colin Hutchinson, chair of Doctors for the NHS, commented on the rhetoric of dissolving the boundary between health and social care. How treatment is classified could become very important, for example in the use of intermediate care beds, and the Care B&B type of model. Are those health, are those social care? The use of rehabilitation services, particularly if they are delivered in patients homes. It raises the possibility of hotel charges for non directly medical care for patients staying in hospital. If you're dissolving those boundaries, it does need to be defined, otherwise people will end up with unexpected bills at the end of their treatment.

Later that afternoon, the Committee asked “Are STPs and Integrated Care Systems unworkable?”

BMA Chair Chand Nagpaul said the whole NHS was unworkable, with 55,000 operations cancelled, 17,000 patients queued up outside Casualty, and corridor management the new norm, all due to the lack of a viable funding settlement despite clear warnings from the highest professional medical bodies and think tanks. Furthermore, the BMA knew that the original STP plans were drawn up primarily to impose cuts and force financial balance come 31st March each year.

For the RCN, Lara Carmona stated “I don't think anyone can answer your question until each of those STPs provide us with the level of data that we actually need in order to ascertain whether that's even feasible... If any changes are ever made solely on the basis of efficiency, we run the risk of compromising patient safety to a degree that's unacceptable and also putting our workforce in conditions that are untenable.”

With that in mind, let's look at some of what the Cheshire & Merseyside STP Chief Executive Mel Pickup and Chair Andrew Gibson told the Wirral Council Adult Care and Health Overview and Scrutiny Committee on 13th February, as videoed by John Brace.

Both officers freely admitted that the STP had got off to a bad start. In fact quite a few Councils and Health and Wellbeing Boards had denounced it vehemently soon after it was eventually published in Nov 2016. As we later discovered, Liverpool City Council only really opposed the geography. They wanted a Liverpool Accountable Care System, but not a Cheshire & Merseyside STP.

Pickup and Gibson focused on geography. They said the STP had been redesigned around 9 localities, coinciding with local authority boundaries for St Helens, Knowsley, Warrington, Liverpool, East Cheshire, West Cheshire, Halton, Sefton, and Wirral. Mel Pickup said “place-based” care was not in the original STP. “That wasn't there, and I think that's where we went wrong.” So it wasn't any of the issues put to the Select Committee, but the lack of “place-based” care. As to governance arrangements for the localities, to avoid duplicating effort “we would seek to do that only once for the whole of Cheshire & Merseyside”. But what are these arrangements, who is drafting them, how is NHS England involved, when will Councillors, healthworkers, their unions, patients and the public get to comment on and influence them? She didn't say, and I don't think she was asked.

Andrew Gibson said “The services that are provided within those boundaries, in local borough boundaries, should be designed by you, and, in conjunction with, NHS colleagues, Local Authority colleagues, Third Sector. We have to live within the finance that we are given, but those funds are for you to decide, collectively with NHS colleagues and others, how that money is spent.”

A lot of issues there. Gibson says that the Third Sector, or unspecified others, will be involved in deciding how to spend the inadequate finance as given and how to design the services. “Third Sector” refers to organisations that are neither public sector nor private sector. It includes voluntary and community organisations, social enterprises, mutuals and co-operatives. “Others” could be anyone, but a very recent Kings Fund publication “Making sense of integrated care systems, integrated care partnerships and accountable care organisations” is relevant. They say Integrated Care Partnerships can include hospitals, community services, mental health services and GPs, while Social care and independent and third sector providers may also be involved. Social care includes the private sector. Independent has a precise meaning in this context. According to the data dictionary published by the NHS, “An [Independent Sector Healthcare Provider](#) is a private sector healthcare company that is contracted by the NHS in the provision of healthcare or in the support of the provision of healthcare.”

So the private sector can be involved in the design of services and decisions about how to spend the finance as given, Gibson signalled without spelling it out. But he insisted “I think I can speak for Mel, that neither she nor I would look to any sort of privatisation of the NHS wholesale, on our watch.”

Wholesale privatisation of the NHS has never been an option – it's too big. But there are at least 6 real options:

1) a private company being involved in designing an ACS (Accountable Care System, now dubbed Integrated Care System) or ACO (Accountable Care Organisation) or however it is rebranded. For example, Centene is a US transnational health insurance company described as a “Care Integrator” - managing a bundle of care which is subcontracted to providers. It owns 50% of Ribera Salud, which pioneered the Accountable Care model in Valencia, and whose private hospital at the centre of that scheme is being renationalised by the newly elected left wing regional government in Valencia. Ribera Salud has recruited Alan Milburn to their Board, to help with their expansion plans. Centene owns 75% of The Practice, which runs private GP surgeries, and has a contract to develop the Accountable Care System in Nottingham, a Labour Council incidentally.

2) a private company replacing the CCG as contract holder in an ACS. Bidders for a community services contract in Nottingham had to agree that their contract could in future be transferred from the CCG to an unspecified “Care Integrator”.

3) a private company getting the lead contract for an individual ACO. This is why Hunt wants to amend the ACO regulations to allow for contract holders which are neither NHS nor local authority bodies.

4) private companies getting contracts for support services for accountable care systems and sustainability and transformation partnerships, as per a new framework announced by NHS England in December. It covers:

- Gathering and distributing health and care data (include deidentification and reidentification of patient data).

- A wide range of support services to make health providers more efficient and financially sustainable including “relationship management and supply chain support” and “waste minimisation”.

- Supporting the creation of personalised health budget and integrated commissioning.

- Building and supporting local health and care records.

- IT infrastructure, cybersecurity, and electronic patient records (the framework will also cover suppliers to the global digital exemplar programme).

- Population health management including business analytics.

- Command centres to support demand management and capacity planning across health economies.

- Support for medicine optimisation.

5) private companies – social care or independent sector - being involved in designing place-based services, as Andrew Gibson signalled.

6) private companies getting individual contracts to provide – either entirely or through joint ventures - specific “back office” or clinical support services. These are mentioned in the C&M STP as options for “commercially sustainable” admin, and “commercially sustainable” pharmacy, pathology, or radiology.

So who is Andrew Gibson, appointed, presumably by NHS England, as the Cheshire & Merseyside “full time independent Chair” last July? Back in 2015 he was the North Tyneside CCG ACO Programme Director. He is also a partner in GibsonFreakeEdge (GFE) , a consultancy. GFE and Capsticks offer a “bespoke procurement support service” for Public Sector Transformation, whose GFE contact point is Andrew Gibson. GibsonFreakeEdge have been paid consultants for Coast, Humber and Vale STP, and also Sussex and East Surrey STP . Independent? Conflict of interest?

Finally, a little bit about Liverpool.

Merseycare December 2017 Board

<http://www.merseycare.nhs.uk/media/4410/x-public-board-pack-dec-2017.pdf> p20 of 24 (pdf)

15. As part of STPs, NHS England are encouraging local NHS organisations to develop Accountable Care Systems, whereby providers and commissioners work together to decide how the STPs will be implemented in practice, and to decide how resources and activity will shift between providers over the next five years. Mersey Care is working with LCC and other stakeholders through the Liverpool Integrated Care Partnership Board to break down the barriers to Health and Social Care Services and as such we are now chairing the Liverpool Provider Alliance of NHS organisations to look at the Integration Care Agenda.

Minutes of the Liverpool Health and Wellbeing Board, Liverpool CCG, and various NHS Trusts make it clear beyond question that Liverpool is developing an Accountable Care System and that the Liverpool Integrated Care Partnership Group was introduced in September precisely to address governance issues for the ACS. A formal proposal was expected to be adopted on 15 March, but now looks to be in June. As of September, the draft plan referred to an “agreed risk/gain share” and stated “all providers who provide care in the City will have accountability for delivery of outcomes... and to each other for this delivery”. This means private sector and NHS organisations will each be accountable to all the others.

The Mayor and Labour Councillors deny any connection between the LICPG and an Accountable Care System, which they profess to oppose, despite their own documents. The Mayor offered to cooperate with us in drafting a joint resolution to Full Council, but then went ahead with their own version, only some of which we could support.

Already, 3 Liverpool CLPs have called on the Council to come in line with Labour Party policy. The Walton resolution reads:

That Liverpool City Council, and its Health and Well Being Board, withdraw all support from Liverpool Integrated Care Partnership Group (LICPG) - which previous council documents make clear is a developing accountable care system. As such, it will contribute to £22billion in cuts to the NHS in England and open the door for further privatisation, turning tax-funded public services into private profits. This is in line with Labour party policy agreed at 2017 conference.

I'll stop there, and other issues can come up in discussion.