Integration and Innovation: working together to improve health and social care for all

Evidence to the Health and Social Care Committee of the House of Commons

Dr Colin Hutchinson, FRCOphth, on behalf of Doctors for the NHS

Doctors for the NHS is an association of doctors, from all specialties and disciplines, that have a strong commitment to the founding principles of the NHS, which are as relevant today as they were in 1948. It is not politically aligned, but recognises the importance of the political process in shaping health and care services. Within our membership we retain extensive experience of working within the NHS over the span of many decades, which allows us a long-term appreciation of the various organisational and clinical changes that have taken place in turbulent times. We wish to use that experience to contribute to the evidence before this Committee.

Doctors for the NHS (DFNHS) respects the aspiration of the White Paper to bring together health and social care services within a structure of Integrated Care Systems across England and agrees that collaboration is a stronger foundation for such integration than competition.

- We welcome the use of the powers of central government to increase fluoridation of water supplies to improve the developing teeth of children, given the difficulty of local authorities to coordinate such action across the whole water supply from our rivers, which does not often respect political boundaries;
- We believe that the concept of a Health Services Safety Improvement Board could at last provide a safe space for candid reflection on factors contributing to adverse incidents, rather than seeking to attribute blame to individuals working within a complex environment;
- We agree that Local Education and Training Boards have proved an unnecessary and ineffective addition to educational structures and should be abolished.

Is the context right for major reorganisation?

The White Paper makes many references to learning from the experiences of the pandemic, but a systematic and open review of the pandemic response has not yet taken place, so how can we be sure that the appropriate lessons have been learned. Many of the measures outlined have been under discussion long before the pandemic struck. DFNHS is concerned that they do more to address the concerns of those who administer health services than those of the people who use them, or work on the frontline.

- Reference is made to major proposals to reform social care and public health services, but it does seem peculiar that structural bureaucratic changes are being

progressed before the anticipated changes in social care and public health have been revealed. How can we be confident that the new structures that have been described will align with the functional needs of these important services? If they don't, further major reorganisation will be required. Surely it would be sensible to consider form and function together.

- There is now much greater awareness of the likelihood of further pandemics in coming years pandemics. Maybe consideration should be given to full re-integration of public health departments into the NHS in England, as they are in all other UK nations. These were all in a very much better position to carry out their own versions of "test and trace", having retained the necessary skills within effective local public health departments, and being able to expand from that base to meet the need . By comparison, the rapidly assembled national system in England has performed woefully in its key role of effective contact tracing, even once testing capacity had been ramped up, at exorbitant cost to the public purse. Diverging health systems in the four nations bring few advantages, but being able to learn from comparing good practice is surely one of them.

The elephant in the room

- The Health and Social Care Committee of the House of Commons has recognised that the lack of effective planning to ensure a sufficient supply of suitably trained doctors, nurses and other clinicians is having a devastating impact on the ability of the NHS to fulfil its role. (1)

- Retention of such staff has also been long identified as a problem, particularly when clinicians feel strongly that they are not being given the resources and support to use and they feel that the care that they are able to provide does not meet the standards they set themselves and that their patients deserve.

- Shortages of appropriately trained staff is also the principal driver behind many reconfigurations of clinical services, is a key contributor to stress in the workplace and a major factor in reducing the safety of patients.

- Workarounds to cope with numbers of trained staff, including flexible deployment of clinicians across wider organisational boundaries, ignores the importance of working

in tight professional teams, in familiar surroundings, where each member of the team knows the capabilities, and the weakness, of other team members and how to use them to their patients' advantage. Place them in unfamiliar teams and they become less effective and patient safety suffers. This is the main reason why reliance on short-term agency and locum workers is a common feature of struggling services. We need to be strengthening teams, rather than diluting them.

- The workforce models that these reorganisations favour ignore the importance of continuity of care in safe and effective treatment. If somebody suddenly falls ill, their priority is for their problem to be diagnosed and appropriate treatment started as soon as possible, so they can be cured and get on with the rest of their life. But for very many people, their ill health is due to a long-term condition that can be treated, but not cured. This includes much mental ill-health. In these circumstances, continuity of care from an individual clinician, or a small team, can foster the best opportunity to develop trust between patient and clinician and to follow an agreed plan of treatment, that offers the best chance to help people to live with their condition with the least possible disability. Understanding patients as individuals, and following them through the course of their illness also strengthens the job satisfaction of most clinicians and encourages staff retention. We need to make continuity of care the norm, rather than an exception and organise our health services accordingly.

- DFNHS finds it difficult to understand why it is thought that a new duty for the Secretary of State to publish a document once every five years should be seen as a sufficient strategy to address a problem of such magnitude. No agreed, costed, workforce plan for the NHS in England has been produced to accompany the Five Year Forward View (2014), or the NHS Long-term Plan (2019), despite the considerable implications for workforce within both these important documents.

- Discharge to Assess is promoted as a means to reduce the duration of hospital stay, and nobody would wish to prolong such stay if there is a more suitable environment in which to continue recovery from illness, but a recent report from Healthwatch and the Red Cross has raised significant concerns as to how Discharge to Assess has been working in practice. More than 80% of patients who were discharged from hospital under these arrangements did not receive an assessment following their discharge. (2) It is vital that such gaps in continuing care are addressed before Discharge to Assess becomes the default pathway.

Commercial contracts or professional standards: which forms the strongest foundation for integrated patient care?

- DFNHS regrets that, over several decades, the restructuring of the NHS in England into a host of contractors and subcontractors governed by commercial contracts and competition that has been focused on headline costs, rather than cost-effectiveness, has been profoundly damaging to patient care and the stability of health services. Safe, effective health care demands the creation and development of stable teams of skilled and multidisciplinary professional staff. Building up such teams and bringing together the resources they require takes many years to achieve, as do the relationships with the broader health and care services which form the context within which they care for patients. The relatively short timescale within which the retendering and awarding of contracts operates profoundly undermines the creation of high performing teams. For teams that perform poorly, there are better ways of improving the quality of care than through a commercial contracting process.

- DFNHS agrees with the removal of all barriers that impede the smooth access of patients to the care that they need. The existence of a framework of commercial contracts encourages providers to work within the confines of their contract, rather than the requirements of the patient or the professional ability of their staff. It does not make commercial sense to exceed the terms of the contract. Such contracts set boundaries to the care that is offered. Clinicians with the ability to deliver the best care that they are able, and with the freedom to hand over care to a more appropriate person when they are reaching the boundaries of their competence, can be much more effective than a reliance of patient pathways, which rarely have the flexibility to tailor care to the specific needs of the patient in front of you. Patients too often are left to navigate their way around this complex landscape and, all too frequently, fall through the gaps between services that are not well co-ordinated in time or place. Many adverse incidents take place at these boundaries.

- The proposals in the White Paper retain a system based on commercial contracts, but the ambition to remove 'unnecessary bureaucracy' removes much of the regulatory framework that ensures the award and monitoring of these contracts takes place transparently and with accountability, in line with the Nolan Principles. Far from removing the market, it replaces a regulated market with an unregulated market: recent reports from the National Audit Office (3) and from the Public Accounts Committee (4) provide examples of hazards of operating without such constraints.

Potential conflicts of interest - how will they be resolved?

The intentionally loose description of structures and their working arrangements, while appearing to be a pragmatic approach to allow flexibility to respond to local circumstances, gives us concern that they could allow a major challenge to the public service ethos which has defined our NHS since its conception.

- The membership of the Statutory ICS NHS Body is very loosely described

    - The ICS NHS Body may include "others determined locally". It is unclear whether this could include private companies offering commissioning support functions, private hospital groups, nursing home chains and other private companies that may, at the same time, be providing services to the ICS. This could be perceived as presenting the opportunity for conflicts of interest if these bodies, or their subsidiaries, are also providers of services. If this is not the intention, then there should be a closer definition of the kind of bodies that may be members of the ICS NHS Body. If it is intentional that this should remain a possibility, clarity is required as to how such conflicts of interest will be resolved.
    - The duty of NHS organisations and Local Authorities to cooperate in delivering services, is being replaced by a duty to collaborate. This duty is going to be subject to guidance from the Secretary of State as to what delivery of this duty means in practice. There needs to be clarity as to the potential impact of this duty on the powers and resources of Local Authorities.
    - The duties of the Body are binding upon all bodies participating in the ICS, but it is unclear whether every Local Authority in the area covered by the ICS will be represented on the Body.

- The ICS Health and Care Partnership is also described very loosely:
    - The wider, undefined membership of the Partnership may again include non-statutory bodies and private providers of services
    - The powers of the Partnership seem to depend entirely on those defined by the particular ICS NHS Body

- Joint Committees may be set up by the Partnership, which can take decisions which are then binding upon the Partnership, with no limit as to the kind of provider that can be a member. There would appear to be considerable opportunities for provider organisations to select the kind of work and the way in which it is delivered in ways that would be most profitable to their organisation, with the risk that less profitable or riskier areas of work could be avoided or minimised.

- Transparency and accountability are essential to good governance and the maintenance of the trust of the public, but DFNHS can find no reference to any duty for any of these bodies to meet in public, publish minutes that are accessible to the public, nor the extent to which they are subject to the Freedom of Information Act.

- Scrutiny of health and care services by Local Authorities may have been inconsistent at times, but has largely been possible through considering the actions of Clinical Commissioning Groups, Local Authorities and other health and care bodies. If these organisations are no longer responsible for key decisions, and it is unclear what

decisions have been taken, when and by whom, the extent to which effective scrutiny is possible becomes very uncertain: indeed there appears to be no mention of such scrutiny anywhere within the White Paper.

New barriers to integration?

If the intention is to remove barriers to the effective integration between health and social care, it is difficult to understand why new barriers should be erected. Local Authorities commission services within the scope of Public Contracts Regulations 2015. The White Paper proposes removing the commissioning of clinical services from the scope of these regulations. It is unclear how joint commissioning between Local Authorities and NHS bodies will work if there are two separate regulatory frameworks.

The greatest barrier to integration between health and social care is the different model of funding and eligibility criteria between a health service that is universally accessible, comprehensive and funded almost entirely through general taxation and a social care service which operates under strict criteria of eligibility and payment for which is heavily means-tested. Only when these barriers are removed can the experience of the patient with long-term needs become seamless and the cost of the associated bureaucracy be removed.

(1) https://committees.parliament.uk/committee/81/health-and-social-care-committee/news/136782/committee-chair-jeremy-hunt-criticises-failures-that-make-a-mockery-of-nhs-workforce-planning/
(2) https://www.healthwatch.co.uk/report/2020-10-27/590-peoples-stories-leaving-hospital-during-covid-19
(3) https://www.nao.org.uk/report/government-procurement-during-the-covid-19-pandemic/
(4) https://publications.parliament.uk/pa/cm5801/cmselect/cmpubacc/932/93206.htm