Building a strong integrated care system

Response to NHSE / I consultation

Doctors for the NHS

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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 1949. 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 this consultation.

What problems are we trying to solve?

1. DFNHS agrees that 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.

2. DFNHS also 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. 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 co-ordinated.

3. Paragraph 1.3 states that the proposals are designed to improve population health and healthcare; tackle unequal outcomes and access; enhance productivity and value for money, amongst other goals, but no evidence is provided of how and why

the organisational and financial integration proposed is likely to lead to improvements. The National Audit Office found 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." https://www.nao.org.uk/report/health-and-social-care-integration

4. The suggestion that the proposed arrangements would replace competition with collaboration needs to be clarified as collaboration and not competition is a very important element. It seems likely that competition will remain a major feature of the NHS, albeit at a lower tier of subcontracting of services.

The workforce crisis

5. The fragmentation of the NHS into an archipelago of financially autonomous organisations has contributed greatly to the workforce shortages, which poses the greatest existential threat to the NHS, and which have been cruelly exposed during the pandemic. It has undermined the collaboration between organisations that was essential to clinical training. Each provider expects to recruit fully-trained staff, but is reluctant to accept the cost and responsibility for playing a full part in that training process. Provider organisations have regarded reducing staffing levels as a key means of meeting Cost Improvement Plans, so they have been reluctant to make clear declarations of shortages to Health Education England, making it harder to ensure appropriate numbers of training places in many specialties. Although para 1.12 states that ICSs will ensure workforce planning, commissioning and development, it is unclear how they will achieve this, or afford the skilled staff that patient care requires. This is too important an issue to be unresolved.

6. Staff deliver their best when working in tight teams, where each member knows their role, know the abilities and experience of the people they are working alongside, the physical layout of where they are working and the other services with which they may need to interact. This local knowledge is crucial to delivering safe patient care and efficient working. Much is made of "developing an agile workforce" and "workforce sharing arrangements" (paras 2.15 and 2.16), but these pay scant regard for the benefits of stable teams of skilled professionals. There is a huge difference between making it easier for staff to work across different locations and organisations if it is their wish, or if it helps them to develop broader professional skills, and compelling them to do so because of staff shortages in particular locations, or organisational expediency. The stress of working in unfamiliar environments, with people you don't know, and who don't know your capabilities

and limitations, can be extreme. Poor retention of highly trained clinical staff has been recognised as a major contributor to our workforce crisis. There is a very severe risk that these proposals could make the situation much worse. Most clinicians recognise that the use of agency and locum staff affects the capacity and safety of the service on offer, often because they take time to integrate with the team.

If the diagnosis is wrong, the treatment won't work

7. One of the greatest barriers to integration of care is the entirely different basis for health services and social care. No kind of organisational restructuring will remove the squabbles over who picks up the bill for an individual patient's continuing care. The NHS is supposed to provide universal, comprehensive healthcare that is free at the point of use. In contrast, social care has strictly defined access criteria, so it is not universal, and is heavily means-tested. Integrated care, and even collaborative care, will be unachievable unless social care is brought in line with health care, as a universal, comprehensive service, funded through a progressive system of general taxation. An examination of the steps that are being taken towards such integration in Scotland may be helpful in this context, although the process is so far incomplete.

8. DFNHS agrees with para 3.1 and that the NHS Act 2006 and the Health and Social Care Act 2012 do not provide a suitable foundation for system working, and have contributed to many of the problems that health and care currently face. We agree that much of this legislation needs to be repealed and we also agree that the four principles outlined in para 2.72 could provide a basis for legislation to replace the structures brought about under these acts.

9. **Question 1 and Question 2 We agree that ICSs should be statutory NHS bodies and that ICSs should take on the statutory duties of CCGs, outlined in Option 2. If CCGs were to retain their statutory functions in commissioning, supervising, monitoring and enforcing contacts, there would be greater clarity of accountability and prevent the creation of an additional tier of bureaucracy, at greater cost and of very little benefit to patient care.**

Transparency and accountability

10. We are concerned that public accountability should be retained at a level that is relevant to people who are using these services and are experiencing them. We wish to see transparency and candour throughout all areas of the NHS. The consultation document does not specifically state that an ICS would be amenable to judicial review, or to a human rights or freedom of information challenge. The requirement for public involvement and consultation in commissioning arrangements and in developing proposals for change need to be ensured (para 2.36-2.38), as does the

ability of members of relevant Local Authorities to scrutinise such changes, as well as the ongoing performance of the ICS and its members. In this context, it is important that these processes can be applied to the whole patient pathway, rather than the part played by an individual provider, to reduce the risk of "offloading" responsibility from one provider to another, which is of no benefit to the patient.

11. **Question 3 We reject the suggestion that ICS membership should be permissive. Commercial organisations have a statutory obligation to place their duty to maximise the returns for their shareholders as their top priority. This can too easily conflict with the aim of using public funds to the greatest public benefit. They should not be allowed to "Shape the strategic health and care priorities for the populations they serve", nor to "Determine how services are funded and delivered." (para 2.44) The ICS should have the responsibility for delivering the highest quality of care possible, within the constraints imposed by national policies, regardless of the commercial interests of its constituent members. ICS membership should be restricted to public bodies .**

12. The suggestion that the ICS should have powers to delegate responsibility for arranging services to providers (para 3.23) seems to compound these concerns. As long as we have a market-driven system of contracting and subcontracting, there will be a need for public servants to retain responsibility for the contracts that are drawn up, and monitoring and enforcing those contracts. It is unclear whether commercial providers would be able to avoid scrutiny of their actions and decisions under terms of "commercial sensitivity."

13. The response to the pandemic has also revealed the risks to good public administration from a contracting system that does not involve open competitive tendering and timely publication of the terms of contracts awarded. https://www.nao.org.uk/report/government-procurement-during-the-covid-19-pandemic/ We profoundly disagree that public health services are best served by an NHS that is defined by a network of commercial contracts and competitive tendering, but as long as that market arrangement persists, the process by which such contracts (and subcontracts) are awarded needs to be transparent and so we are very uneasy with the recommendations in para 2.61 unless there is complete clarity on the governance arrangements that would replace them.

14. We also reject the involvement of commercial bodies in Commissioning Support Units (para 2.67), which have enormous power to shape the services experienced by

the public and the bodies commissioned to provide those services. The rationale for CSUs was that the necessary skills for commissioning were too thinly spread within CCGs. The move away from a CCG-based model to a smaller number of larger ICSs should be used to bring these functions and the body of expertise back in-house, to be served by public employees serving only the public interest.

Boundaries

15. DFNHS seeks assurance that the ICS would be responsible for every person living within its geographic boundaries, rather than some other definition of its responsibility. We see some benefit in services currently commissioned by NHSE becoming the responsibility of the ICS, but there needs to be clarity in the arrangements by which people can receive the treatment they need, if it is not available within the area covered by the ICS, or if personal choice or circumstances require them to seek treatment outside that area. Such freedom of choice existed in the NHS until the 1990s, but has been subverted by the commissioning of services. It is important that it should be restored.

16. On a similar theme, there needs to be clarity on resolving issues when a patient's ICS has chosen not to provide a particular service, but it is available in another ICS.

17. **Question 4 The rationale for retention of specialised commissioning by NHSE was originally that services for uncommon conditions was required at a regional or national level and could be 'forgotten' amongst the priorities of an individual CCG. The definition of a 'specialised service' has been rather arbitrary, in some cases, leading to removal of such services from smaller hospitals, even when the quality of those services was high, and contributing to the decline of the District General Hospital and its attractiveness to clinicians. Much more detail needs to be provided as to the 'safeguards' mentioned, before we can answer this question.**

The drive to centralisation

18. DFNHS welcomes the recognition of the important role of the NHS as an anchor institution in communities across the country (para 1.15) in social and economic development, as well as training and employment.

19. Despite this, there has been a continuing drive to centralise services, with closure of local departments and smaller hospitals. There is remarkably little evidence to support the assertion that centralisation consistently improves quality or reduces

waiting times" (para 1.18) and evidence of sustained improvement, where such changes have occurred, is very hard to find. As paragraphs 1.9 and 1.20 state, "decisions taken closer to the community they affect are more likely to lead to better outcomes and fair access".

20. The Long Term Plan appeared to recognise the value of smaller hospitals and staff with broader clinical skills, which has allowed the NHS to respond more flexibly to the pandemic. Reconfiguring services can easily destabilise the continued provision of the remaining services in such units. "Developing provider collaboration at scale" (para 1.18 -1.21) could easily be interpreted as an encouragement to centralisation.

Clinical and professional leadership

21. DFNHS welcomes the recognition of a strong clinical and professional involvement in the design, evolution and continuing delivery of services that straddle institutional boundaries and that are based on the clinical needs of patients, rather than the business models of the participating organisations.(paras 2.24-2.27) A generation of clinical leaders has grown up in an environment in which serving the interests of their employing organisation may have been seen as their principle objective and the route to career advancement. There needs to be greater recognition of the value in listening to apparently dissenting voices, particularly from frontline colleagues, and diligently exploring the points they raise. This would include encouragement and support for professional forums in which frontline clinicians could exchange views across disciplines and organisations, the time to be able to participate, training to be able to understand the broader context within which services are developed and delivered and the people skills essential in presenting ideas and seeing them through to completion. This should be seen as a core responsibility of all senior clinicians and supported by their employing organisations.

Appearances matter

22. DFNHS is opposed to models of care in England that are based on the Health Maintenance Organisation. It may be unintentional, but the emphasis on patient pathways, the use of data and digital tools to confine the treatment of individual patients and stratify risk and the delegation to providers of decisions on what services to provide and in what way, would be consistent to laying the groundwork for an insurance-based health system. We are sure that this is unintentional, but it needs to be made very clear that this is not the direction of travel.