Academy of Medical Royal Colleges

Health and social care integration: joining up care for people, places and populations

Academy of Medical Royal Colleges response to DHSC white paper

Introduction

The Academy of Medical Royal Colleges is the representative body for medical royal colleges and faculties in the UK. We speak on standards of care and medical education across the UK. By bringing together the expertise of the medical royal colleges and faculties we seek to drive improvement in health and patient care through education, training and quality standards.

Given the Academy's remit, our response to this Department of Health and Social Care (DHSC) white paper on integration focuses on cross-cutting issues in medicine within the wider context of health and social care.

Executive summary

The Academy welcomes the move towards greater integration and supports the vision for more joined-up personalised care that addresses health inequalities. Close consideration of the systemic barriers to these changes is vital. Meeting the ambitions set out in the white paper will only be possible if workforce shortages and resource constraints are adequately addressed.

Context

The Academy and its member organisations strongly support the development of integrated care systems (ICSs) and more integration both within the NHS and between the NHS and local government. This presents vital opportunities to improve patient outcomes, tackle health inequalities, and provide person-centred care, all aims of our Rethinking Medicine and Choosing Wisely initiatives.

We have long emphasised that the fragmentation of services which emanated from proposals in the 2012 Health and Social Care Act was detrimental to the effective delivery of joined-up patient care. We have consistently argued that collaboration between clinicians and organisations will achieve the best outcomes for patients, as the response to the COVID-19 pandemic has illustrated.

Our views on integration have been set out in our previous responses to the 2020 NHSE/I engagement document Integrating care — Next steps to building strong and effective integrated care systems across England, the 2021 DHSC white paper on health and social care, and the 2022 Health Select Committee inquiry on workforce issues. In these documents we set out that, among our member organisations, there is consensus and recognition that:

- Giving ICSs a statutory footing provides the right foundation for the NHS over the next decade.
- This offers a model that provides greater incentive for collaboration and clarity of accountability across systems to Parliament and, most importantly, to patients.
- Legislation itself rarely creates cultural and behavioural change, but it can provide a framework to support and remove barriers to change.
- Clinical engagement and leadership in ICSs are key and we want to see this made a reality.
- Any NHS organisational change can distract attention from service delivery and improvement. Sensitive handling of change and minimising disruption is essential, especially following the pandemic.
- There is an overwhelming need for full reform of the social care system.

We support the vision for more joined-up working across different professional groups and systems. We have outlined the principles for collaborative team-working and gathered case studies of good practice in our reports Developing professional identity in multi-professional teams (2020) and Multi-professional team-working: The experience and lessons from COVID-19 (2021).

Outcomes

Shared outcomes can play an important role in forging a common purpose between partners within a place or system, as demonstrated in the collective effort to respond to the pandemic. The case studies in our report on team-working and COVID-19 show how an outcomes-led approach can help break down barriers between different specialties and healthcare settings. We know, however, that system pressures pose a challenge to sustaining this approach and increased demand may see a return to more siloed working. Supportive leadership and sufficient resourcing will be vital to maintaining the momentum.

There is a role for setting outcomes at both local and national level. We welcome the proposed focus on prevention and tackling inequalities (recognising the wider social determinants of health), which are widely agreed to be crucial to improving population health and the sustainability of the whole health and care system. We welcome the white paper's commitment to further consultation with stakeholders, including the public, on shared outcomes.

Leadership, accountability and finance

Clinical engagement and leadership in ICSs will be key to delivering the vision for integrated care. There is growing evidence on the importance of clinical leadership in securing improved patient outcomes. The pandemic fostered a step-change, with clinicians engaged more effectively and encountering fewer barriers and less bureaucracy. Clinical leaders can help drive culture change and should be supported and encouraged to take on roles in challenging circumstances or organisations.

ICSs must have the infrastructure to support and make clinical engagement a reality whether through clinical networks, input to planning processes and quality assurance. The medical royal colleges and faculties will want to work with NHS England nationally and ICSs locally to ensure this happens.

The precise workings of governance are not necessarily of direct relevance to our member organisations, although there should be an appropriate and transparent balance between national and local accountability.

We understand the importance of the expectation to have a single person accountable for the delivery of the shared plan and outcomes in each place or local area, but also recognise the challenges raised by NHS Confederation in their white paper briefing. It is important that there is clarity in whatever arrangements are decided.

The role and regulatory responsibilities of the CQC in integrated systems will be very important. The Academy has arranged a seminar for Academy members with Dr Rosie Benneyworth, Chief Inspector of Primary Medical Services and Integrated Care at the CQC to talk through the issues and provide input to the development of the regulatory framework.

Financial arrangements should work to enable and support collaboration and integration and not act as barriers. The Academy supports the Health and Social Care Bill's proposals to remove the jurisdiction of the Competition and Markets Authority in respect of Trust mergers and the decision to repeal Section 75 of the 2012 Act, which promotes competition over collaboration. To ensure best value in the use of public funds, there must be mechanisms in place which are independent and robust when required but not unnecessarily burdensome and disruptive.

Workforce

The white paper sets out plans to bring about a more 'agile' workforce and we welcome proposals such as the integrated skills passport to enable staff to move across different settings, opportunities for cross-sector training, and the use of new roles which co-ordinate care across boundaries. We know, however, that staff shortages across the system are the biggest challenge facing health and social care. Expanding our workforce – alongside optimising the use of multi-professional teams and new ways of working – will enable more joined-up care and more effective collaboration across sectors and settings.

The Academy, alongside more than 100 other health and care organisations, is calling for an amendment to the Health and Care Bill which will strengthen long-term workforce planning. The amendment would give a national, independent view of how many health and social care staff are needed to keep pace with projected patient demand over the next 5, 10 and 20 years. While some important work is already underway, such as HEE's Framework 15 review, this is focused on thematic supply and demand drivers and does not look at the numbers needed in the system. A collective national picture of the workforce numbers needed now and in the future will provide the strongest foundation to make long-term strategic decisions about funding, specialty and regional staff shortages, skill-mix changes and population health.

Integrated Care Boards (ICBs) will have a significant role to play in workforce planning and strategy at regional level. They can identify local population health needs and seek to address specialty shortages. However, ICBs will not have the levers necessary to make high-level policy changes. For instance, they cannot ensure national investment, expand and redistribute training places, or amend immigration policies. Nor can they bring about systemic changes that affect recruitment, training and retention across the four nations. While we welcome ICBs' role in driving local assessments of workforce supply and demand, there remains a pressing need for responsibility and accountability at national level. Greater clarity is needed on how the activities of ICSs and ICBs will form part of a national workforce strategy committed to long-term projections and planning.

Digital and data

The vision for digitally enabled care, set out in the NHS Long Term Plan, was accelerated during the pandemic. The opportunities and challenges presented by this step-change must be carefully considered. Many patient groups have reported greater accessibility of healthcare, and some of the barriers to data sharing across systems were removed. We know, however, that there are real risks of digital exclusion that must be mitigated, particularly for already disadvantaged groups. A hybrid model balancing both face-to-face and remote ways of working, which takes into account

digital inclusion and clinical necessity, is likely to be most effective for patients and practitioners.

Expansion of remote monitoring programmes holds great potential for being able to virtually monitor the health status of patients while at home. This may allow earlier detection of deterioration in the community, empower patients to better monitor their own acute or chronic health conditions, and help with assessment, optimisation and monitoring of patients before or after surgery. Remote monitoring programmes expand the responsible healthcare team across primary, secondary and community settings.

More joined-up data – as articulated in the proposals for population health platforms, population health management and shared care records – presents real opportunities to improve outcomes and tailor care, but it relies upon optimising communication and collaboration across IT systems and reassuring patients about the privacy of their personal health data.

With greater use of technology in healthcare, ongoing education and training of both patients and the workforce will be key, as the white paper recognises. In order to be able to deliver digitally enabled care, health and care staff also need access to improved IT systems and modern equipment. Systems will require complementary digital infrastructure if they are to work together more effectively and this will require investment across the system.

The white paper notes the 'rapid adoption' of technology seen during the pandemic should be maintained. While we agree that many of the positive changes brought about by new ways of working should be built upon, we are cautious about this focus on speed of adoption, particularly at a time of huge pressures for the system. The use of new technologies must be carefully evaluated to understand the impact on clinical outcomes and on the experience of practitioners and patients. The pace of change during the pandemic sometimes meant that patients and the public were not involved in service redesign. Their input should be sought, as we know routinely co-producing services with patients can enhance experiences of care and reduce health inequalities.