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Nature of interest

For several years until recently I have chaired a local volunteer 'health and wellbeing group' in Dorset, trying to understand the entirety of services and to make these clear to residents. This meant working closely with commissioners, with managements of provider organisations, and with many of the saints and heroes of the NHS and care organisations.

Experience of the system

Our experiences 'on the ground' have shown that, pre-pandemic, NHS provision here was often poorly coordinated, lacking both effective links between health and social care, whether adults or children, and a common approach with Public Health. The result was public confusion, and destabilisation for front-line staff. In reality, integrating health and care has fallen to patients and carers. The growth of 'care navigators', 'signposters', 'linkworkers' etc (themselves badly in need of coordinating!) under the social prescribing banner indicates how impenetrable the system had become to its users.

While shortage of funding and other resources is a factor, structural issues are at least as significant: thus the monotonous government-spokesperson mantras that "we have invested £x billion in the NHS" infuriatingly miss the point.

Learning from Covid

The Covid experience has taught us such a lot about the skill and dedication of staff and operational management at the sharp end: nimbleness, imagination and effectiveness when professionals close to the ground have determined to act on need, unhampered by procedural nit-picking. Those are values on which to build reform. It has also shown that nationally-controlled bureaucracies are relatively ineffective. Throughout the last Covid-year our Clinical Commissioning Group, for example, has been irrelevant and futile, a non-contributing watcher from the sidelines while the people who matter have got on with doing an outstanding practical job.

The need for real integration

Long-term, nothing will significantly change while the system is divided into mini-empires with their varying lines of accountability, separate executive teams, and – crucially – discrete budgets. When the Department of Health became the Department of Health and Social Care we hoped that the logic would work through the system: but it has not.

Looking from the bottom up, a necessary, though not sufficient, step is surely to reunify the service so that the Department of Health and Social Care leads a single national Health and Care Service? In England, NHS England would become 'Health and Care England', managing regional (county-based?) integrated Health and Care England authorities. Those authorities would then take over the (few) essential roles of Clinical Commissioning Groups, which would be abolished. They would also take on responsibility for Public Health from the county council, which would also hand over to them responsibility for adult and children's social care. Short-term contracting would end.

That would establish coherent governance and management top-to-bottom, with a framework for integrated governance and management of services to defined local populations. Within such a structure,

and given local leadership responsive to both staff and public input, it would be possible to provide a cost-effective service comprehensible to its users, more rewarding for its professionals, and more appealing to volunteers.

An opportunity to grasp

This chance to reform the health and social care system won't come again for a long while. So let's hope that it avoids the pitfalls of previous attempts, whereby bureaucracies simply changed names, shuffled functions around without thought as to their purposes, and retained many of the old staff with new job titles. It cannot be right, for example, that many of the employees of our CCG are former doctors, nurses, physiotherapists etc doing desk jobs when the NHS is desperately short of trained people. Radical surgery on the bureaucracy would cut out much of the confusion and overlap in function that marks the present over-complex structure, would remove those pointless tasks that bodies such as CCGs accrue to themselves, and would enable many of their people to return to the work for which they were trained at taxpayer expense, thus filling at least some of the gaps in front-line staffing.

A danger to be avoided

It makes complete sense that the *national* health and social care service should be coordinated at the top by a ministerial department determining policy, objectives, funding and the like. But this must not become a 'command-and-control' culture restricting, or interfering with, properly-delegated operational responsibility and control at regional / local level.

In a well-organised and managed system, simplification does not require centralisation, while central accountability is perfectly consistent with local responsibility.

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