Written evidence submitted by The Royal College of Physicians (HSC0934)

Summary

The Royal College of Physicians (RCP) welcomes this inquiry on the department of health and social care's white paper *'Integration and innovation: working together to improve health and social care for all'*.

The RCP is supportive of the proposals in the white paper to realise the ambitions of the NHS Long Term Plan and to support and underpin the transformation already taking place in the health and care system to deliver integrated, person-centred care. Legislation alone will not achieve that aim, but these proposals provide a framework for it.

The legislation also provides an important opportunity to establish transparency and accountability on workforce planning. We welcome the proposal that the secretary of state publish a report once a parliament that clarifies roles and responsibilities for workforce planning. This must be underpinned by workforce projection data published at regular intervals to ensure transparency about future demand on the NHS and the workforce needed to manage it. **We want to see the Bill place clear legal responsibility on a designated body for publishing workforce projections and place a duty on the secretary of state to respond to those projections with a plan for what government will do.**

The notable omissions on social care reform and the future of public health functions currently owned by Public Health England make it difficult to assess the future health and care system as a whole. While we welcome the population health approach, without tackling the drivers of health inequalities at a national policy level, the local interventions of integrated care systems (ICSs) can only go so far. Given the health inequalities that the pandemic has exposed and exacerbated, this must be a priority.

Recommendations

- The Bill should place clear legal responsibility on a designated body for publishing workforce projections. The secretary of state should have a duty to respond to those projections with a plan for what government will do.
- Government should commit to developing a cross-government strategy on reducing health inequalities as ICSs will not be able to reduce health inequalities without the support of national policy.
- The better health and wellbeing element of the triple aim must include an ambition to reduce health inequalities.
- Government should publish its proposals on the future of Public Health England and on reform of social care as soon as possible to enable policy makers and clinicians to view the system as a whole.
- A clear plan for communicating change to staff and sensitive handling of change to minimise disruption is essential, especially given many healthcare staff will be focused on tackling and recovering from the

pandemic. While this change has been happening in some areas for a few years already, legislation can be difficult to communicate. It is vital that policymakers spell out clearly the rationale for changes and how they may affect healthcare staff and their day-to-day clinical practice.

Delivering integrated care for patients

1. The structure of Integrated Care Systems

1.1. We support the principle of putting ICSs on a statutory footing, to provide the framework for a more integrated approach to delivering healthcare. We agree that legislation alone rarely creates cultural and behavioural change but these proposals provide a framework for it.

1.2. We strongly support the ICS health and care partnership bringing together the NHS, local government and other local partners to develop a plan for the health, public health and social care needs of its population.

1.3. The membership of the ICS health and care partnership, and its relationship with the ICS body, will be crucial to ensuring there is the right expertise to deliver a successful population health approach. While there are dangers in being prescriptive on membership, having all relevant organisations and bodies involved will mean the best chance of successfully delivering the vision set out in the white paper.

1.4. For example, involving public health expertise and leadership in the partnership and body will be key to a successful population health approach. The voluntary, community and social enterprise (VCSE) sector will have an important role in delivery and must be involved in developing plans, as should strong patient and clinical voices. Health and health outcomes are affected by many things beyond the control of the NHS, such as housing and access to green spaces, which local authorities or community organisations manage. A diverse partnership will enhance the consideration of, and action on, the wide range of issues which contribute to good health.

1.5. Given this, **we would welcome greater clarity on the relationship between the partnership and the body to ensure that all stakeholders are meaningfully involved and that voices outside the NHS are heard.**

1.6. The white paper does not give much detail on ‘place’. Much of the integration of services is happening at place, not ICS, level – and much of the innovation seen during the pandemic was seen at place level too. While we are not expecting ‘place’ to be defined in legislation, more information is needed on how the system will work at that level and how the integration and improved partnership working developed during the pandemic can be maintained.

1.7. Some ICSs are more developed than others. It is important that support and guidance is given to fledgling systems so they can learn from those that are more established and more experienced.

2. Triple aim on health bodies and other duties

2.1. We support the 'triple aim' duty on health bodies to pursue better health and wellbeing, better quality of health services and sustainable use of NHS resources. These shared aims for the system should provide a framework for facilitating better integrated working between members of the ICS partnership and ICS body, as well as between the partnership and the body.

2.2. We welcomed that the secretary of state for health and social care said in his evidence to the select committee on 16 March 2021 that the ultimate measure of success for ICSs would be improved healthy life expectancy. The pandemic has exposed and exacerbated the health inequalities that existed before COVID-19 hit. **The RCP believes the better health and wellbeing element of the triple aim should include an ambition to reduce health inequalities. Different levels of responsibility for reducing health inequalities should be made clear in guidance: what must be done at place, trust, ICS and NHS England level.**

2.3. Bringing together a range of stakeholders across health and care should mean that ICSs have a better starting point to tackle some of the non-clinical factors which affect health. But an ICS' ability to prevent ill-health locally will only go so far unless the overarching determinants of health are addressed at national policy level. As equalities minister Kemi Badenoch MP said in her letter to the prime minister and secretary of state for health and social care in October 2020, 'a range of socioeconomic and geographical factors such as occupational exposure, population density, household composition and pre-existing health conditions'[1] appeared to be contributing to the higher mortality rates for different ethnic groups.

2.4. The triple aim might incentivise an ICS to prioritise access to green spaces for exercise, drawing on the resource of the local authority and local VCSE as partnership members to make that happen, but it cannot ensure people have enough money to eat healthily. **The government must develop a cross-government strategy to reduce health inequalities,** assessing what national policy change could complement the work being done locally under ICSs.

2.5. The triple aim should also encourage ICSs to prioritise clinical research. The population health approach of the new system provides an opportunity for ICSs to support and commission research tailored to the needs of its population to ensure better health and wellbeing and better quality of services.

2.6. Sustainability of NHS resources is an important part of the triple aim. Climate change is the biggest global threat to health and the NHS is responsible for around 4% of the nation's carbon emissions.[2] Patient care should never be compromised, but it is important that we consider the impact of health interventions on

[1] Letter from equalities minister Kemi Badenoch MP to the prime minister (2020) 'First progress report on addressing COVID-19 health disparities'

[2] NHS England (2020) 'Delivering a net zero national health service'.

the planet. RCP strongly supports the targets set in 'Delivering a net zero national health service', but our members tell us that they want to know how they can support the ambition for the NHS to reach net zero by 2040[3] in their day-to-day clinical practice. Guidance on how to implement the 'sustainability' element of the triple aim will be necessary to support a long-term meaningful shift in thinking on this issue, from planning to commissioning and delivery of services.

2.7. We support the proposals on the Duty to Collaborate, Collaborative Commissioning, Joint Committees and Data Sharing.

Delivering long-term plans for the health and social care system

3. Ensuring the NHS has the workforce it needs

3.1. We welcome the secretary of state committing to publish a report once a parliament to clarify roles and responsibilities on workforce planning. In our 2019 submission to the health and social care select committee's *NHS Long-term Plan: legislative proposals* inquiry we called for a national accountability framework on workforce planning. We said there should be a specific duty on the secretary of state to ensure a health and care workforce that is sufficient to meet the needs of the population.

3.2. The report once a parliament will bring much needed clarity to the system on the process of workforce planning. It is welcome that the report will be co-produced at a minimum with Health Education England (HEE) and NHS England (NHSE). But better long-term workforce planning is crucial to the ability of the NHS to deliver better integrated care, so there needs to be greater transparency and accountability than is currently offered by the white paper proposal.

3.3. It is important that the data used to project and meet demand for health and care services are made public so they can be effectively scrutinised. As long as decision making takes place out of the public domain it will remain difficult for the health and care system to make plans for service delivery and expansion, and for policymakers to assess whether we are training enough people now, and in the right roles, to meet future demand.

3.4. The Bill should place a duty on a designated body to publish workforce projections, and a duty on the secretary of state to respond to those workforce projections with a plan for what government will do.

3.5. While a designated body will not provide a definitive answer on how many staff we need to train, publicly available workforce projection data based on modelled patient demand would allow effective scrutiny of policy decisions on workforce. The RCP would like to see an arrangement similar to that between the Home

[3] NHS England (2020) 'Delivering a net zero national health service', p5: for emissions it directly controls.

Office and the Migration Advisory Committee (MAC), where an independent recommendation is made public before a final ministerial judgment is taken.

3.6. The designated national body must have an understanding of the health and care system and have links to both the NHS and the department of health and social care (DHSC). It could be a new body or, as has been suggested in the Committee's inquiry, HEE could be given a legal duty to publish independent estimates of long-term workforce needs at regular interval so they can be revised and updated. The RCP supports projection data from HEE or NHSE being put in the public domain so they can be scrutinised.

3.7. The process described by the secretary of state in his oral evidence to the select committee – *'what you need is transparency from Health Education England and a public debate around what the judgment should be'* – is a model we would therefore support. If HEE was made the designated national body with a responsibility for publishing workforce projections, its programme of work in this area would need to be reviewed and likely expanded to ensure it was modelling the entire health workforce.

3.8. Whether the designated national body is an existing body like HEE or a new one set up for this purpose, it should undertake a population-based assessment of the NHS workforce's ability to meet patient need across the entire health and care workforce in the medium and long term. It must project demand for all types of clinicians in health and social care - doctors, nurses, medical associate professions, allied health professions and others. It should be aligned to national level service plans underway, such as the NHS Long Term Plan, and in future should develop workforce plans at the same time as national service plans.

3.9. This mechanism of a duty to publish workforce projection data, followed by a duty for the secretary of state to respond to those data with a plan for what government will do, will help to incentivise long-term thinking and increase transparency and accountability. Close working with the education system will also be needed, for example to expand the number of medical school places available, and workforce plans will need to be underpinned by a multi-year funding settlement.

3.10. Consideration should be given to whether once-a-parliament is a sufficient timeframe for both the designated body to publish projection data and for the secretary of state to respond. Long term thinking is vital, and so this process should take place not less than once every three years. This will allow time to begin to implement plans in response to the workforce projection data, while ensuring the workforce modelling is as up-to-date as possible.

4. Training

4.1. We recognise there is a case for removing of Local Education Training Boards (LETBs) from statute, but there must be a strong regional model that enables input from the clinical and employer voice in place.

5. The future of social care and public health

5.1 The notable absence of detail on key areas such as social care and public health makes it harder to assess the future system in its entirety. Giving an ICS responsibility for population health is likely to lead to greater investment in and focus on preventative measures, but this needs to be complemented by increased funding for public health. **Before the legislation comes to parliament we need to see proposals on the role of the National Institute for Health Protection (NIHP) and where functions currently held by PHE will sit in future so we can assess how all parts of the future system will fit together.**

5.2 **The long-awaited proposals from government to reform the social care system need to be published.** This needs to include a sustainable funding plan. The ambitions of the NHS Long Term Plan will not be achieved without an effective social care system. A properly resourced social care sector would ease the pressure on hospitals by reducing the number of people who need to be in hospital in the first place, and make it easier for them to leave more quickly.

5.3 The proposals relating to obesity are welcome and we fully support the initiatives suggested. Research from the World Obesity Federation's latest report showed that 30% of COVID-19 hospitalisations in the UK were directly attributed to overweight and obesity, and three quarters of all critically ill patients had either overweight or obesity.[4] This has reiterated that the financial and human costs of obesity are high.

5.4 The causes of obesity are complex. We have long called for restrictions on the advertising of high fat, salt and sugar foods as part of our work with the Obesity Health Alliance (OHA) and so this proposal is a significant welcome step. But given that eating healthy food comes second to eating at all for one in five people in England who are living in poverty, government should consider obesity as part of a cross-government strategy to address health inequalities.

Reducing bureaucracy and additional proposals

6.1 The RCP is generally supportive of replacing the existing legal requirement for all assessments to take place prior to discharge with a 'discharge to assess' model where continuing healthcare, funded nursing care and care act assessments will take place after discharge. Some physicians have already been working in this way during the pandemic and found that it helped to improve patient flow. However to be effective and prevent unplanned readmissions, discharge to assess will need to be underpinned by the necessary resource, especially in community services.

[4] World Obesity Federation (2021) 'COVID-19 and obesity: the 2021 atlas'

6.2 We welcome the proposal to repeal the competition role of the Competition and Markets Authority.

6.3 We support NHS England and NHS Improvement merging to become NHS England.

6.4 We support the creation of Medicines and Healthcare products Regulatory Agency (MHRA) medicine registries.

6.5 We support putting the Healthcare Safety Investigation Branch (HSIB) on a statutory footing and the creation of a statutory medical examiner system within the NHS.

6.6 We support the review into hospital food standards.

6.7 While the white paper proposes the power to remove a profession from regulation, it is unclear whether there is similar provision to add a profession into regulation. Being able to do this where there is agreement seems important given the growth of advanced roles and multi-professional team-working.

6.8 We welcome the assurance on the need for proper consultation on any proposals for transfer of functions between arms-length bodies (ALBs). Stakeholders, including the affected ALBs, must be meaningfully engaged and their views heard on any such proposed transfer of functions.

Contact

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About the RCP

The RCP plays a leading role in the delivery of high-quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians in the UK and overseas with education, training and support throughout their careers. As an independent body representing over 39,000 fellows and members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare. Our primary interest is in building a health system that delivers high-quality care for patients.

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