

Integrated Care

Sarah Wollaston Chair, Health and Social Care Committee, Chair, Liaison Committee (Commons)

I beg to move, That this House has considered the Seventh Report of the Health and Social Care Committee, Integrated care: organisations, partnerships and systems, HC 650, and the Government Response, Cm 9695.

It is a pleasure to serve under your chairmanship, Dame Cheryl. I thank all those who contributed to our inquiry in writing and in person, my fellow Select Committee members, and the Select Committee team, which was ably led by our Clerk, Huw Yardley, with special input from Lewis Pickett. I also thank our special advisers, Professor Sir Chris Ham, Dr Anna Charles and Professor Pauline Allen.

We are all immensely grateful to the South Yorkshire and Bassetlaw sustainability and transformation partnership, the Doncaster Royal Infirmary and the Larwood practice, not only for allowing us to meet them and their teams, but for facilitating the Committee's meetings with local and national leaders from across the healthcare system, the third sector and many other providers to hear evidence during our inquiry. Without them, the report would not have been possible.

I will start by setting out what we are talking about, and why it matters. It is one of the greatest triumphs of our age that we are living longer but, as that happens, many more of us are living with complex, long-term conditions that require support and input not only from dedicated family and formal carer networks, but from across the health and social care system. If those systems do not join up, if they do not share information, or if they are poorly co-ordinated or inaccessible, patients' care is poorer and everyone has a worse experience. Don Redding from National Voices, said that patients and the public "want to feel that their care is co-ordinated, that the professionals and services they meet join up around them, that they are known where they go, that they do not have to explain themselves every single time, and...that their records are available and visible." That is essentially what we mean by integrated care.

Integrated care can happen at three levels. It can happen directly, in the teams around the patient who deliver care in the patient's home—for example, through joint assessments. It can happen at the service level—for example, with services brought together in a one-stop clinic. It can happen at an organisational level—for example, in commissioning or the pooling of budgets. We should all be clear, however, that none of that matters unless we keep the patient at the front and centre of those discussions. If the result is not delivering better care for patients and their families, it is not worth doing.

Integration does not save money in the short term or, sometimes, in the medium term, which acts as a key barrier to putting in place integrated systems for the long-term benefit of patients. Unfortunately, particularly with the current financial pressures, we have a system that is sometimes dictated and hampered by short-term pressures to deliver financial

savingsâ€”I will come on to that later. In essence, we have to keep sight of the fact that integration is about people and families. Although our report focuses on organisations, partnerships and systems, we have tried to relate it back at every stage to why it matters to patients, rather than it being a dry discussion about systems.

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Sarah Wollaston Chair, Health and Social Care Committee, Chair, Liaison Committee (Commons)

I thank the hon. Lady, my fellow Committee member, for her input. We on the Committee heard that there is a complex spaghetti of acronymsâ€”STPs, ICPs, ACOsâ€”and nobody knows what they mean. Even those working in the system struggle to keep pace with them and with the changes. We have to keep bringing it back to plain English and why it matters to people and hold our attention there.

The integration of health and social care has been a long-term goal for successive Governments for decades, so we might ask why it is not happening everywhere if we have been striving for it for so long. We saw and heard about many fantastic examples of good integrated care, but they sometimes felt like oases in a desert of inactivity. It is also possible to have an area that does some things very well but others not so well.

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Sarah Wollaston Chair, Health and Social Care Committee, Chair, Liaison Committee (Commons)

I will respond further to the hon. Lady's remarks when I comment on legislative change and how we can get legislative change through a hung Parliament. I will also comment on the importance of engaging with the service and why that needs to come bottom-up from the service, and the importance of politicians from across the House listening to the service and being focusing on its message and the message from patients and patient representative groups. I thank her for her constructive input. The Committee has been successful in building consensus about how this should go forward. I hope the Minister has heard that intervention and that he will respond specifically to that point in his closing remarks.

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Sarah Wollaston Chair, Health and Social Care Committee, Chair, Liaison Committee (Commons)

Coming back to why integrated care does not happen, there are many deeply ingrained structural divides. Since the inception of the NHS 70 years ago, we have had a system that is free at the point of use for the NHS, but means-tested for social care. That presents an extraordinary hurdle when systems are trying to join up. It is not just that; it is different contractual arrangements and working practices. Good integration comes down to individuals and teams being prepared to work together, but it often feels like they are working together to achieve integration despite the systems around them, not because of them.

We need a system where everybody is focused on helping the right kind of integration to take place, and we need to go back and look at that fundamental structural divide between the systems. I ask the Minister to look again at the joint report, "Long-term funding of adult

social care", because that is an important issue that goes to the heart of the barriers to joining up services. It is about contractual differences, different legal accountabilities and payment systems that work against the pooling of budgets, and financial pressures within the NHS.

A certain amount of financial pressure can encourage systems to come together to pool their arrangements and provide a more efficient service, but as the Minister will know, when the elastic is stretched too tight and the financial strain becomes critical, we see the opposite—systems are forced apart. I have seen that happen in my area, where people suddenly feel that they have to retreat to their organisational silos to fulfil their legal obligations. There is no doubt that, for the process to work effectively, we need the right amount of funding—and sufficient funding—and tweaks to the legislative arrangements to allow people to come together, so it does not feel as if they are working together despite the system.

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Sarah Wollaston Chair, Health and Social Care Committee, Chair, Liaison Committee (Commons)

I thank the hon. Member for that intervention and for her own service to the Committee previously—she is very much missed. Her remarks are typical of the constructive input that she has always made to the health debate in emphasising the need to take the long view. Financial pressures so often force us into short-term solutions, not only in the way she set out but through the salami-slicing of services.

One of the points that our Committee feels strongly about and that I was going to make to the Minister is the need to ring-fence transformation funding, because it is so easy for that funding to get lost. I welcome the uplift in funding—a 3.4% increase will be very helpful—alongside a 10-year plan. However, we have to be realistic about what that uplift can achieve, because there are very many demands on that budget, as the Minister will know and as we have seen in the past. We saw it with the sustainability and transformation fund, which tended to get sucked into sustainability and not into transformation. That has been the pattern of recent decades. There is good intention to ring-fence money for transformation, but that money disappears because of other priorities around deficits and, as I have said, the many other calls on the funds available.

That is why we feel that, in order to prevent the continuation of that cycle of past mistakes, it is important that the pattern is recognised and that funding is earmarked for transformation—not only for capital projects but for things such as double-running.

I will give an example from my area. There will be a complete destruction of public trust in new models of care if money is not set aside for double-running. The community was prepared to accept that there would be a new facility—nobody wanted the closure of the local community hospital in Dartmouth, but there was an assurance that there would be a new facility. Unfortunately, despite many of us opposing the closure of the old facility, what happened was that it was closed and then there was a breakdown in the arrangements for the new facility. The community was left with nothing and there has been a huge destruction of public trust in the process, which unfortunately will have ripple effects across other communities. Had we received the money to keep the existing service while the new service was built and got up and running, it would have left us in an entirely different situation. I am afraid that we see that too often across health and social care. There is good intention, but without double-running, which is part of having a ring-fenced transformation fund, I am afraid

that the system has broken down too often in the past. I would like the Minister to focus on that when he makes his remarks.

The Committee is also looking forward to the 10-year plan—we look forward to working alongside both NHS England and the Department of Health and Social Care to examine how that plan emerges—but is important to draw attention to legislative changes. Our Committee made a recommendation that legislative proposals should come from the service itself rather than top-down from the Department, which would immediately run into difficulties. However, as a Committee we also offered to subject such proposals from the service to pre-legislative scrutiny.

As Diana Johnson pointed out in her intervention, we need to build cross-party consensus at every point. As it has not been covered in the formal response to the Committee's report, will the Minister say in his closing remarks whether the Government would support the Committee conducting pre-legislative scrutiny?

I am pleased to have had a conversation with Simon Stevens, the chief executive of NHS England, who has confirmed that, as it emerges, the NHS assembly will consider that within its remit—NHS England hopes to produce proposals in draft form before Easter 2019. Nevertheless, as I have said, it would be helpful to receive the Minister's assurance that proposals will come to our Committee for pre-legislative scrutiny as part of the process of building consensus.....

Sarah Wollaston Chair, Health and Social Care Committee, Chair, Liaison Committee (Commons)

Hon. Members know that a lack of proper pre-legislative scrutiny that responded to concerns expressed led to many of the barriers. We have to go back and address them when they could have been addressed in a more collaborative process during the passage of the Health and Social Care Act 2012. I am thinking of the need to reconsider the legal basis for merging NHS England and NHS Improvement, and how we establish a better statutory basis for the process so that provider partnerships do not always have to go back to separate boards to gain their approval. It is about considering how we address issues such as geographical arrangements so that they make more sense to local communities. The Committee could play a constructive role in a host of areas but—I say this to the Minister—unless proposals are subjected to pre-legislative scrutiny and unless a cross-party consensus is established, proposals are likely to fail.

My final point—other Committee colleagues will probably want to develop it further—is this: what will happen around establishing a legal basis for integrated care providers? For two reasons, the Committee welcomes the change of name from "accountable care organisations" to "integrated care partnerships". First, the original name confused the debate about Americanisation. The "accountable care organisations" proposed were not the same as those organisations in the States, and the original name caused a great deal of unnecessary anxiety. We do not see the process as Americanisation.

A concern raised with the Committee was that the process will be a vehicle for privatisation. We did not agree. In fact, we thought the opposite: we agreed with the witnesses who told us that the process provided an opportunity to row back from the internal market and away from endless contracting rounds, and move towards much more collaborative working. We would like that change to be properly reinforced within the legal status of health bodies, and are disappointed that the Government have not agreed to say categorically that these bodies would be classed as NHS bodies. When the Minister sums up the debate, I would like him to

reflect on whether any form of wording can put the matter beyond doubt and ensure that these health bodies will not be taken over by large, too-big-to-fail private sector organisations.

It is not a concern that groups of GPs might want a leading role in the bodies. The Minister will know that the public concern is more about them being taken over by very large too-big-to-fail private sector organisations. It should be possible to come up with a solution. The Committee heardâ€”the Minister knows thisâ€”that those working in the service have the view that the bodies are not likely in practice to be taken over by private sector providers. However, that public concern exists and is a barrier to change. If we can put this matter beyond doubt, we should try to do so.

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Sarah Wollaston Chair, Health and Social Care Committee, Chair, Liaison Committee (Commons)

I thank the hon. Lady for her helpful clarification. I was trying to distinguish GPs, who are private contractors to the NHS. Sometimes that status is used as a reason why integration cannot be done. I do not think there is concern about that level of leadership involvement but, as she rightly points out, there is concern about other aspects of the private sector. It is acting as an unhelpful distraction when there should be a consensual approach to ensure, as I said at the beginning, that we keep focused on the purpose, which is to provide better services for patients. Anything we can do to facilitate making it easier for that to happenâ€”rather than feeling like we are wading through treacleâ€”will be a positive way forward.

I thank my colleagues and all who helped with the inquiry.