



***Health and Social Care: Delivering Integration  
Labour Party Challenge Paper  
Submission from the Royal College of Surgeons***

The Royal College of Surgeons welcomes the opportunity to comment on the Labour Party's challenge paper *Health and Social Care: Delivering Integration*. The paper, along with recent speeches from party spokespeople, has set out some thoughtful ideas to tackle the issue of integration which the health sector is united in ascribing importance to. We particularly welcome the support given to integrating services, to reconsidering the role of the district general hospital, the emphasis on prevention, centralising specialist care, and the need to strengthen the independence of healthwatch.

The RCS also appreciates the opportunity to comment on policy development at an early stage. Although the Party stresses that no top down reorganisation of organisations is proposed, creating one budget for all types of care would have significant implications and it is right that serious debate is held in advance of any more detailed proposals. We would also like to see greater clarity about the role health professionals could play in the proposed reforms. There is a risk that moving commissioning to health and wellbeing boards will distance commissioners from clinical experts and undermine improvements aimed at involving doctors and nurses in the reforms of recent governments.

The RCS is keen to contribute its expertise to all major political parties' policy development. Given the 'challenge paper' sets out initial thinking rather than detailed proposals, our response focuses on principles and sets out some questions for further consideration by the Labour Party.

**Integrating health and social care**

The RCS believes that greater integration among physical and mental health, and social care professionals along the care pathway is a positive move for both patients and clinicians. The RCS believes integration is best achieved by the professional accountability of a single-named consultant assuming overall responsibility for a patient's care – something which the Shadow Secretary of State recently supported in his response to the Mid-Staffordshire NHS Foundation Trust inquiry report. This needs to be backed by strong communication between the patient and clinical team to ensure a seamless patient experience.

In addition to clinical benefits to patients, cost benefits such as reduced length of stay in hospital settings are also achievable through integration of services. These cost benefits are not always directly delivered to commissioners though, and therefore the RCS has

continually emphasised that it is important to address issues of funding in order to avoid financial disincentives and barriers to integration.

The RCS believes that a number of other issues are worthy of consideration under the headline of integration including:

- **Accountability for care:** We believe a named consultant should be clinically responsible for a patient admitted under their care from the initial referral/consultation until they are formally discharged following treatment. A named consultant should ensure that there are formal and explicit handover arrangements when transferring their patients to another named colleague when unavailable for any reason. We would welcome further discussions with the Labour Party on how this can be achieved in practice.
- **Information:** Information about and for the patient is also essential in helping to provide an integrated patient pathway. Access to clinical information about the patient is essential for clinicians in a handover and non-clinical information such as lifestyle or family support is also important as it can affect decisions on the treatment proposed or the timing of discharge. The role of information should be considered as part of Labour's review.

### **Questions for further consideration**

The RCS supports the principles set out in the challenge paper. We also have a number of questions that require further debate and consideration. These questions do not imply criticism, but we would welcome clarification as part of any more detailed policy response.

### ***Role of the medical professions***

To date the Labour Party has not made clear what role the medical professions would have in a unified care system. The Shadow Secretary of State has said the Health and Wellbeing Board (HWB) could have the primary role for commissioning health and care services. Although the HWB is currently required to have a representative of the local CCG on the Board, in theory this could be a managerial rather than a clinical representative. It is also unclear what would happen to clinical senates and clinical networks which have been established as the focal point for the development of clinically led best practice and guidance.

### ***Role of the NHS Commissioning Board and the risk of postcode lotteries***

As well as commissioning some services such as dentistry and specialised surgery, the NHS Commissioning Board also has an important role to play in setting standards for commissioners and reducing postcode variation. For example, its draft clinical policy for bariatric surgery<sup>1</sup> complies with NICE's guidance and will help to reduce rationing in the

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<sup>1</sup> [https://www.engage.commissioningboard.nhs.uk/consultation/ssc-area-a/supporting\\_documents/a5policy.pdf](https://www.engage.commissioningboard.nhs.uk/consultation/ssc-area-a/supporting_documents/a5policy.pdf)  
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health service. Clarification about both the role of the NHSCB and how rationing would be reduced in a system where commissioning may be carried out by local councils would therefore be welcome.

### ***Politicisation of decision-making***

There is an obvious risk that the proposal for health and wellbeing boards, which are situated in councils, to commission physical and mental health services may lead to the politicisation of some healthcare decisions. There may be an argument that greater democratic legitimacy would be welcome for some commissioning decisions where difficult ethical decisions have to be made, but it would not be appropriate for political reasoning to trump clinical evidence for the commissioning of most healthcare services. Consideration also needs to be given to the impact on transferring decision-making about reconfigurations to local councils who, in the past, have often led opposition to clinically-justified service redesigns. In this context it will be useful to monitor the impact transferring public health functions to local government in April 2013 makes on decision-making, especially since some public health issues are high-profile and may attract local controversy.

### ***A single budget for physical and mental health, and social care***

Successive governments have experienced difficulty in centrally monitoring how local government budgets are spent. Consideration needs to be given to how existing physical and mental health budgets will not be reduced at the expense of spending on other non-health areas a council has responsibility for.

### ***Use of technology to improve care***

Harnessing information technology has the potential to improve patient experience as well as the delivery of care. Currently a range of paper based and electronic systems exist in hospitals which make it difficult to track the movement of patients within the hospital but also between primary, secondary care and social care settings. We believe these can be improved by the use of technology such as electronic management systems and electronic patient records.

### ***Integrated education and training***

The development of Health Education England has reflected moves towards the education and training of the whole health care workforce. This has been broadly welcomed as a way to raise standards and promote multi-professional training. Clarification is needed on what further integration is required.

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