Royal College of Anaesthetists

January 2018

Royal College of Anaesthetists' response to the Health Select Committee inquiry into Sustainability and Transformation Partnerships and Accountable Care Organisations

Summary of our response and key recommendations

We welcome any initiative that improves patient outcomes and quality of care, and believe that the integration of services to provide a more coherent patient pathway is the right direction for the health and social care system.

Any decisions with respect to the development of Sustainability and Transformation Partnerships (STPs), and the further progress of the New Care Models programme, must be shaped by considerations of the quality of patient care; not the financial health of providers.

Clinicians must be fully involved in the development, governance and delivery of the New Care Models and there must be proper consultation with patients and patient groups to inform decision-making. Neighbouring STPs and the larger Accountable Care Systems (ACSs), and latterly Accountable Care Organisations (ACOs) must also work in a coordinated way to ensure that decisions taken by one geographic area do not negatively affect another.

Key recommendations

- NHS England and NHS Improvement must increase efforts to ensure clinical engagement in the development, governance and delivery of the STPs and other New Care Models programme, which must be coupled with proper consultation with patients and patient groups. For their time, expertise and professional input, all stakeholders should be appropriately remunerated for their contribution
- There should be a clear plan for clinical engagement through the existing Clinical Senates network[1] and appropriate STP clinical forums, that must be adequately (re)aligned to the geographic boundaries and patient populations of STP areas
- All STPs must have proper assessment regarding their impact on staffing requirements in anaesthesia, critical care, operating theatres and pain medicine services. This includes - but is not limited to - trauma, resuscitation, retrieval, invasive radiology, in-patient services requiring sedation or advanced pain relief, or the availability of intensive care
- With the development of the New Care Models programme, NHS England and NHS Improvement must ensure that there is equity in the way transfers of care and retrievals are budgeted particularly when they cross boundaries.[2]

If you require any further information, or clarifications, please contact Chris Woodhall (Policy & Public Affairs Manager) at cwoodhall@rcoa.ac.uk or on 020 7092 1690.

About the Royal College of Anaesthetists

- Sixteen per cent of all hospital consultants are anaesthetists making anaesthesia the single largest hospital specialty in the UK[3,4,5]
- Anaesthetists play a critical role in the care of two-thirds of all hospital patients[6] and 99% of patients would recommend their hospital's anaesthesia service to family and friends[7]
- With a combined membership of 22,000 fellows and members, representing the three specialties of anaesthesia, intensive care and pain medicine, we are the third largest Medical Royal College by UK membership.

We support better integration of the health and social care system to alleviate resource and capacity pressures, which risk compromising patient care

The health and social care 'transformation agenda' in England places emphasis on reducing hospital activity. The Secretary of State for Health and Social Care has previously stated, "The STPs are very simply about reducing hospital bed days per thousand population and reducing emergency admissions" noting that £4 billion of the NHS's £22 billion efficiency savings will be found in demand reduction.[8]

We are concerned that the pursuit of reduced hospital activity, and the associated financial savings, is being undertaken without a clear blueprint to improve the capacity in out-of-hospital care. In the medium-to-long-term, this will have a considerable negative impact on the ability to deliver high-quality secondary care services. In the immediate-term, the failure to meet the target for delayed transfers of care (DToCs) set in the NHS Mandate highlights the severity of the current problem.

Some STP plans indicate targets to reduce hospital activity that from this starting point can be considered unreasonable and unachievable.[9] For example in one London STP, a 44% reduction in inpatient bed days is expected to be realised because of the new models of community care by 2020/21 (against baseline).[10]

In December 2017, the RCoA published the results of a survey of 500 anaesthetists that revealed the impact that DToCs were having on vulnerable patients.[11] The survey, developed in collaboration with Alzheimer's Society, found that more than half of anaesthetists would be uncomfortable with a relative or close friend with dementia being admitted to an NHS hospital during the winter period. Overall 92% of respondents were 'very worried' (64.4%) or 'somewhat worried' (27.6%) that levels of bed occupancy resulting from DToCs will impact the ability to deliver safe care this winter.

The results of the survey demonstrate the impact that DToCs were having on the proper functioning of hospitals, stifling proper patient flow and creating anxiety among clinicians who see first-hand the combined impact of resource-pressures and limitations on capacity. The King's Fund notes that delays in discharging patients also affects the flow of patients through a hospital… when a hospital is close to full capacity delayed transfers can mean there are no beds available for new admissions, with consequences for waiting times in A&E departments and for planned surgery.[12]

We welcomed the decision, in January 2018, to expand the remit of the now Secretary of State for Health and Social Care, which we believe should help to facilitate coherent decision-making to underpin an integrated and seamless health and social care system. With this broader portfolio the Department for Health and Social Care must work with NHS England and NHS Improvement and professional bodies, including the Medical Royal Colleges, to re-evaluate any plans to reduce hospital activity which do provide fully-costed and clinically-supported plans for the provision of out-of-hospital care.

The Institute for Fiscal Studies (IFS) provides this cautionary assessment: '…although per-capita spending was at a historical high of £2,160 per head in 2015-16 (2016-17 prices), on

average individuals will be older and therefore likely to require more health services than ever before.'[13]

The principles underpinning the RCoA's perioperative care programme are demonstrably aligned with the aims of New Care Models programme

Research from The Nuffield Trust found that some STPs are targeting up to 30% reductions in selected areas of hospital activity, including outpatient care, A&E attendances and emergency inpatient care.[14] These reductions are being planned in the face of steady growth in all areas of hospital activity, including the doubling of elective care over the past 30 years.[15] It seems clear therefore that maintaining the required levels of patient care in parallel to the pursuit of a reduction in activity, will require a major overhaul of how patient care is delivered – and the layout of the care pathway.

The RCoA believes that our initiatives in perioperative medicine, providing a clearer pathway of care from the moment the patient is considered for surgery until they have fully recovered, could provide improved patient care, shortened hospital admissions, and improved efficiency in the provision of elective surgery.[16] Perioperative medicine is a natural evolution in healthcare, using existing skills and expertise to provide an improved level of patient care[17] that closely aligns the underlying principles of the transformation agenda.

Each of these 44 STPs, within a defined geographic area, have identified a number of priorities that show clear coalescence with perioperative medicine principles. A review of just a small sample of the 44 plans reveal that a number of STPs include initiatives and priorities that closely align with the different components of our perioperative medicine vision[18]:

- West Yorkshire and Harrogate STP sets a goal to 'ensuring patients are optimised for surgery'[19]
- Northumberland, Tyne and Wear and North Durham STP outlines one of its priorities to 'Support Fresh and Balance, and a region-wide approach to obesity, NICE smoke free standards across all NHS and local authority health and care services and contracts and Implement a stop before your op pathway for elective surgery'[20]
- The Suffolk & North East Essex STP implementation document identifies a review of a number of care pathways – including surgical pathways – as a key tenet of its plans[21]
- Preventative medicine, i.e. lifestyle modification with smoking cessation, reduction in alcohol consumption, increasing levels of physical activity and weight management are core features of a number of STPs, e.g. Dorset, Devon, Cheshire and Merseyside, Greater Manchester Partners.

Six of the STPs also propose using the *Getting it Right First Time* (GIRFT) methodology to identify performance improvements in hospital clinical acute care.[22] Anaesthesia and perioperative medicine is one of the work streams of the GIRFT programme; the GIRFT leads for this work stream are the (joint) clinical leads for the College's perioperative medicine programme.[23]

Implications for the anaesthetic, intensive care and pain medicine workforce

All STPs must have proper assessment regarding their impact on staffing requirements in anaesthesia, critical care and pain medicine services. This includes, but is not limited to, trauma, resuscitation, retrieval, transfer of patients; including repatriation from tertiary

services, invasive radiology, inpatient services requiring sedation or advanced pain relief, or the availability of intensive care.

Many STP documents indicate plans for the reconfiguration of some services. In this context it is vital that all clinical services continue to support education and training to ensure that doctors in training in the specialties of anaesthesia, intensive care medicine and pain medicine are able to access appropriate supervised and accountable learning opportunities to fulfil the requirements of the Certificate of Completion of Training (CCT) curriculum.

Issues concerning adequate workforce provision will be central to the success of STPs and sustainability of the wider health and social care system. A 2015 report by the Centre for Workforce Intelligence found that the number of anaesthetists and intensivist CCT holders needed to meet demand by the year 2033 would be 11,800 full-time equivalents, which is nearly double the current level of around 6,100. This represents a 33% shortfall based on the projected 8,000 professionals that are set to be trained by this date.[24]

While financial targets are being set to 2020/21, workforce projections highlight the need for planning to be taken this date. Though we welcomed Health Education England's draft workforce strategy (published in December 2017), we are concerned that the strategy introduces another new concept of Local Workforce Action Boards (LWABs) which are described as '…effectively the workforce arm of the STPs'. However, it appears that LWABs have been conceived entirely independently of STPs and the boundaries of LWABs and STPs are not coordinated.[25]

STPs workforce plans may include the growth in the deployment of Medical Associate Professions (MAPs) including Physicians' Assistants (Anaesthesia) (PA(A))s. We support plans to increase the training and employment of PA(A)s in order to augment clinical service delivery, however this workforce must be adequately resourced, supported by a well-defined training structure, and underpinned by statutory regulation.[26] The Department of Health and Social Care has recently consulted on the regulation of MAPs and we have provided representation in support of a statutory framework for PA(A)s, regulated by the General Medical Council.[27]

Accountability, statutory role and financial position of the new care models

The Conservative Party's 2017 general election manifesto all but acknowledged statutory uncertainty in the health and social care setting. The manifesto document stated, 'If the current legislative landscape is either slowing implementation or preventing clear national or local accountability, we will consult and make the necessary legislative changes.'[28]

The *Next Steps on the Five Year Forward View* document outlined that STPs are non-statutory bodies that will 'supplement' rather than replace the accountability of local healthcare bodies, after a number of organisations have questioned the legal basis for STPs' decision-making powers.[α] The House of Lords Select Committee on the Long-term Sustainability of the

[α] For example the report from think-tank, Reform, highlights that 'Some STPs have created MoUs to establish shared objectives. Although these have no legal status,' (pp.17-18). The report notes the 'perception' that competition law is a barrier to integration (p.18). **Report reference**: Laycock, K et al. Saving STPs: Achieving meaningful health and social care reform. February 2017

NHS has also recognised the 'considerable ambiguity' of statutory arrangements of new care models.[29]

The King's Fund noted that the development of STPs and their underlying goals represented '…a decisive shift from the focus on competition as a means of improving health service performance in the Health and Social Care Act 2012'.[30] This assessment appears inconsistent with a response during health questions in October 2017 when the Secretary of State for Health and Social Care confirmed that the legal accountability for commissioning decisions would remain unchanged regardless of any outputs of consultation on governance and commissioning arrangements.[31]

Some clinical commissioning groups (CCGs) have already begun the process of merging with a single, shared accountable officer[32] and/or a combined budget[33] citing reasons such as the pursuit of financial efficiencies. It is too early to assess the effectiveness of these changes, but they will require close scrutiny – particularly from NHS Improvement.

The *Five Year Forward View* proposed the 'triple integration' of primary and specialist hospital care, physical and mental health services, and health and social care. The scope of STPs is to cover all areas of CCG activity as well as integration with services managed by local authorities, including social care and public health programmes (such as smoking cessation services).

A recent report from the National Confidential Enquiry into Patient Outcome and Death[34] reviewed the management of mental health disorders of patients admitted to acute general hospitals with co-existing physical ill health. Anaesthetists will often be involved in the care of these patients in the acute setting, but due consideration must be given to ensure that the appropriate psychiatric – or other specialist support – is accessible in the acute setting.

In March 2017, NHS England published its delivery plan, *Next Steps on the NHS Five Year Forward View*[35] that presented a vision for the evolution of STPs. The document outlined that STPs will be encouraged to become ACSs which will exist within the geography of the STP (or an identified sub-area) once they have appropriately 'evolved' – aiming to end the purchaser-provider split.

The document notes that ACSs will be offered a single 'one stop shop' regulatory arrangement in the form of streamlined oversight arrangements with NHS England and NHS Improvement. In an interview with the *Health Service Journal*, NHS England Chief Executive, Simon Stevens, said that 'STPs will also now be expected to form a basic "governance and implementation 'support chassis'", which will include an STP board and CCG committees in common'.[36]

As the regulatory arrangements remain fluid, due consideration will need to be given regarding the potential for continuous reporting demands to detract from the process of implementing change.[b]

[b] This was a theme which emerged from attendees at The King's Fund Annual Conference in November 2017 particularly following the publication of the initial STP dashboard in July 2017

ACSs will be able to agree an Accountable Performance Contract (APC) with NHS England and NHS Improvement with new arrangements for managing defined population funding.[37] There appears to be considerable uncertainty regarding the contractual arrangements that will be put in place to ensure a fair payment system where patient care requires the crossing of an STP / ACS / ACO boundary.

The perceived incompatibility of the current national tariff payment system with the strategic goal of many STPs to reduce hospital activity was noted in a recent report from the National Audit Office, on the theme of 'Sustainability and transformation in the NHS'.[38]

However, we believe that these arrangements can be resolved without legal recourse and do not support any actions that could force an 'unravelling' of integration of health and social care services since 2014.[39]

The politicisation of the NHS – perpetuated by ongoing dispute as to the validity of a Brexit dividend – does nothing for the service other than to distract from the reality that a 'business as usual' approach will not sustain the quality of care that patients deserve. We welcomed the comments in the House from the Secretary of State for Health and Social Care in which he stated:

'….as we come to the end of the five year forward view, we need to seek a consensus on the next stage for the NHS. We will need significantly more funding in the years ahead, and we need to build a national consensus on how to find that funding. My view is that we should try to do that for a 10-year period, not a five-year period'.[40]

The Prime Minister has seemingly dismissed the call for a decade-long funding settlement and a greater degree of political consensus on the direction of health and social care policy. In her response to a November 2017 letter signed by 90 MPs from across the political parties, Theresa May provided few details on the government's plans for addressing the challenges facing health and social care. Contrary to the view taken by Jeremy Hunt, the Prime Minister indicated that Downing Street is not yet looking beyond the timelines the five year forward view.[41]

The House of Lords' Select Committee report on the long-term sustainability of the NHS[42] published in April 2017 recommended the establishment of a new Office for Health and Care Sustainability, which we would strongly support.

The experience of the Better Care Funding planning process underlines the difficulty in finding consensus between the component parts of the health and social care system in addressing long-term challenges such as the operability of the interface between secondary and tertiary care.[43]

The sustainability of services is a consideration that has to precede their transformation. If the 'transformation' of patient pathways or structures is the means by which the sustainability can be facilitated then we will continue to support the New Care Models programme.

We recognise the positive ambition inherent in the STP programme and the development of ACOs, but it is our view that the goal of achieving sustainability in the health and social care system cannot be assured without levels of funding advised by an independent and apolitical organisation. Ultimately, it will be the availability of the necessary levels of funding, equitable systems of payment and the engagement of clinicians who can provide high-quality leadership - with structured training and central administrative support - which determines the success, or failure of the New Care Models.

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