SOCIAL POLICY RESEARCH FOR CORNWALL

25 July 2022 https://spr4cornwall.net

How Cornwall's Integrated Care System got off to a stumbling start

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EXECUTIVE SUMMARY

- Cornwall's newly created Integrated Care Board (ICB) has adopted the guiding principle that 'decisions about health and care services should be taken at a local level by health and care practitioners and clinicians'. In this it is disregarding the enlightened approach advocated by NHS England, who stress that design and delivery of services should be led by partnerships involving local residents and users of services.
- Unfortunately, when it comes to taking decisions clinicians and practitioners have frequently displayed limited ability to reason from factual evidence outside their specialisms, or to challenge proposals from officers, or indeed to identify and respond to the interests of local people. [Evidence: The record of Kernow CCG, GP patient surveys, current issues.]
- The ICB has designated board members and an invited group of practitioners and clinicians, together with members of some voluntary bodies, as 'partners, stakeholders and thought leaders', and enlisted them without their consent as disciples of a 'consensus' vision of Cornwall in the future, in the manner of a cult. [Evidence: record of a 'True North' event in Newquay, June 29-30, 2022.]
- The ICB is being led on a path where 'research' is interpreted as market research and folded into 'reputation management', thereby treating health care as a commodity and ignoring the vital need for knowledge and understanding of how the health and social care system functions. [Evidence: published job advertisement and correspondence from the ICB Chair.]
- The ICB has failed to take as its starting point real issues experienced by Cornwall residents: these include ambulance delays, the retention in acute hospitals of patients labelled 'medically fit for discharge', the lack of a community hospital in the far West of the county, and the peremptory withdrawal from GPs' surgeries of treatment to remove ear wax. [Evidence: contemporary reports, records of the True North event and the ICB meeting of July 14th, 2022.]

Introduction

On July 1st, 2022, NHS Cornwall and Isles of Scilly's Integrated Care System (ICS) officially came into being. It is headed by an Integrated Care Board (ICB), which has announced that its guiding principle is that 'decisions about health and care services should be taken at a local level by health and care practitioners and clinicians'.

As it happens, NHS England has already specified that within every ICS there are to be

> place-based partnerships, [which] will lead the detailed design and delivery of integrated services across their localities and neighbourhoods. The partnerships will involve the NHS, local councils, community and voluntary organisations, ***local residents, people who use services, their carers and representatives*** and other community partners with a role in supporting the health and wellbeing of the population. *(italics mine)*

In the statement quoted above, Cornwall's ICB, legally responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the ICS area, makes no reference to involving local people in decision-making at local level. Why not? Because, it appears, health and care practitioners and clinicians have already been given – or have taken – the power to set the rules about decision making. The institutional status quo is evidently set to continue.

Medical and social models of health

Giving primacy to clinicians (and their opposite numbers in social care) is part and parcel of the 'medical model' of health care, which has permeated unquestioned the governance of the NHS ever since it was created 75 years ago.

The medical model of health postulates that behind every ailment there is a direct cause-and-effect mechanism at work which it takes a professional clinician to identify and – using standard accepted procedures, such as medical examinations, tests, or a set of symptom descriptions – to remedy (if possible). This is an expert-knows-best model, which requires lay people to accept the clinician's judgement.

Two sub-variants of the medical model have emerged in recent times: the 'continuity model', which emphasizes the ongoing relationship between clinician

and patient and is promoted by the Royal College of General Practitioners, and the 'episode model', on which acute hospitals are organized, which describes how medical and surgical care is regarded as comprising self-contained episodes of treatment.

There is another, very different, model of health, which has become widely acknowledged: the 'social model', which recognises that an individual's health and wellbeing are strongly influenced by social, cultural, environmental, economic and political factors besides medical ones. The social model is being actively promoted by New Local and is already being acted on widely by social prescribing link workers. To quote the National Academy for Social Prescribing:

> Social prescribing connects people to practical and emotional community support, through social prescribing link workers, who are based in GP practices and take referrals from all local agencies. Link workers have time to build trusting relationships, start with what matters to the person, create a shared plan and introduce people to community support.

GPs as managing directors

Cornwall's ICB has appointed three managing directors (MDs), one for each of Cornwall's integrated care areas (ICAs): West Cornwall; Central Cornwall; and North & East Cornwall. (Each of those three areas is a 'place' in the current official terminology.) Each of them is a local GP who will continue to spend around half their time working in their Practice (two in their GP surgeries, Helston Medical Practice and St Agnes, and the third in the Liskeard community hospital.

Are GPs the right people to take decisions? Do they know what is best for their local population? Will they feel any obligation to involve local people when they take decisions? It is almost unknown for GPs to consult their surgery's own Patient Participation Group even when taking a decision that will affect patients.

Have our GPs actually had any management training (none is provided at medical school)? Their medical training and experience are such as to have indoctrinated them with the expert-knows-best medical model of health. Are their minds open to the social model?

Crucially, will they resist instructions from the centre that are clearly not in the best interests of local people: will they have the determination that this calls for

and the ability to argue their case? Have they taken on board that Integration of health care with social prescribing must begin in our GPs' surgeries: what will they do to ensure that they all rise to this ambition?

For the two MDs who work in local surgeries we can gain answers to some of these questions from the responses of their patients to the GP Patient Survey. This is an independent survey run by Ipsos MORI on behalf of NHS England. Questionnaires are sent out to over two million people aged 16 and over, across England, so a sample of every practice's patients receive one. The 2022 results, published in mid-July, show how people feel about their GP practice.

The practices of the two surgery-based MDs are at Helston and St Agnes. Extracts from the 2022 Patient Surveys for the two Practices are shown in the table below.

	Helston Medical Centre	St Agnes Surgery	All Cornwall & Isles of Scilly
% of patients who find it easy to get through to this GP practice by phone	38%	86%	60%
% of patients who find the receptionists at this GP practice helpful	89%	94%	88%
% of patients who usually get to see or speak to their preferred GP when they would like to	41%	62%	43%
% of patients who describe their overall experience of this GP practice as good	80%	94%	79%

It does appear that the partners and management at Helston could learn something from their counterparts at St Agnes. We may justifiably question whether their management skills and, importantly, their desire and ability to learn from others, are up to the mark.

Does integration mean leaving it to an in-group of clinicians and practitioners to collaborate?

At the end of June 2022, the Board-designate held a two-day event at a hotel in Newquay. Branded 'True North', a report on it was submitted to the meeting of the IC Board on July 14th. The 70+ attendees are variously referred to as 'stakeholders', 'partners' and 'thought leaders'. They were brought together by invitation 'for two days of collaboration to shape the future health and wellbeing of the county'.

The report records 'key event outputs':

> Together we agreed our collective vision: Cornwall and Isles of Scilly is a great place to be born, live and grow old. / Together we agreed our collective aim: Connected, healthy, caring communities for one and all.

And five 'key messages':

> 1. We, the leadership from Cornwall, came together to agree an aim and framework for the future – focused on the people of Cornwall and Isles of Scilly.
>
> 2. This was different because we came together for the greater good and have been collaborative and open.
>
> 3. We have a big ambition – connected, healthy, caring communities for one and all.
>
> 4. It's not going to be easy – it's a joint commitment to deliver our priorities.
>
> 5. Judge us not by what we say but what we do.

What do these statements tell us? These 'outputs' and 'messages' need to be called out. They are affirmations. Taken in conjunction with the membership nomenclature – 'stakeholders', 'partners', 'thought leaders', 'We, the leadership' – they amount to an attempt to create an in-group. The repeated phrases 'Together we agreed', 'our collective vision', 'our collective aim', denote an in-group that

has a belief system with an underlying presumption of consensus, an in-group from which you may well be cast out if you dissent. This is not only an in-group in the making: it is an in-group with several of the hallmarks of a cult.

The report to the ICB seems to demonstrate no recognition among the promoters of the event that among the population of Cornwall there are groups of people with a wide variety of health and social care needs, who make a wide variety of demands upon the health and social care system; that these demands give rise to claims on limited resources; and that arbitrating among these claims is an inherently political process.

When these claims come up against the system what we see are *issues*. If I can't get to see my preferred GP I have an issue. If my elderly parent has had a bad fall in the middle of the night and no ambulance is available, we have an issue. If there is no community hospital near where I live, so that if when I am discharged from the acute hospital for convalescence after treatment I am sent somewhere far from home, I have an issue. If I suffer from loss of hearing because of a build-up of ear wax and my GP's surgery no longer provides a treatment for removing it, I have an issue.

Issues arise when people encounter the integrated care system and find their needs cannot be met without a long wait, if at all, and when decisions have to be taken about how to allocate limited resources among competing claims. Such issues bring those who work in the integrated care system into conflict with one another, yet the report on the True North event makes no mention whatever of their having been noticed, let alone discussed. Avoidance of reality is yet another manifestation of cult behaviour.

Wanted: a reputation manager

Cornwall's Integrated Care Board has recently advertised for a Director of Engagement and Communications. The job description says the person appointed will combine engaging with patients and the public with 'reputation management'.

It is troubling to learn that the Board is seeking to recruit someone to combine the role of 'reputation manager' – otherwise known as 'spin doctor' – with doing the job of communicating with patient groups and the public.

These are two incompatible tasks. Communicating with patient groups and the public requires a willingness to listen, tolerance of non-establishment views, an enquiring mind that is open to other people's ideas and capable of unbiased reasoning, and a commitment to discovering and upholding the public interest.

Reputation management, as we see from the job description, involves taking sides: deciding on the Board's behalf who the 'key stakeholders' are, 'campaigning' to promote your 'strategies', and ensuring that your 'core messages are targeted and well received'. None of these is consistent with engaging in any kind of partnership with patients and the public.

And as for giving the reputation manager responsibility for 'health and care citizen related research', as the job description says, that is not only misguided but plain laughable. Speaking as a researcher myself, with more than 50 years' experience, the last people to entrust with research management are spin doctors!

The ICB Chair has responded to the above comment, which was made in an open letter, as follows:

> "Speaking as a qualified Market Research Society researcher myself and with decades of major organisational change, also having been both a Marketing director, or as a Transformation director or as a Commercial director including Comms for some of the biggest brands in the world – or as a CEO – I can share my view that understanding the needs of disparate groups of customers, citizens, users, partners, patients, residents etc and engaging with them in our service re-design has been key and key to that also is two way comms."

What we see plainly displayed here are two entirely different concepts of 'research'. One (mine) is investigation into how complex systems work, into causes and effects and how they are connected; the other – market research – is centred on identifying what customers want or need. The former is particularly called for when it comes to designing systems, for example those involving patients 'flowing' through a hospital, and in investigating and rectifying obstacles to a smooth flow.

Market research is conventionally geared to finding out what prospective customers or users want and will be prepared to pay for. Although we can certainly think of patients as having 'user needs', in the NHS they will not have to pay to satisfy them, and it will be up to others – clinicians (in the widest sense of the word) and practitioners – to determine what treatment they require. To regard NHS treatment as a commodity may not be helpful, especially as it will predispose towards continuing the pre-ICS arrangements regarding a treatment as one or more self-contained episodes (the episode variant of the medical model) rather than an on-going relationship between clinician and patient (the continuity variant).

(One well-known outcome of the pre-ICS arrangements was that if a patient was referred for condition A and then found to have condition B (as well, or instead), that 'episode' had to be declared closed, the patient returned to their GP and the whole process re-started for the new condition: not exactly a rational process.)

How to create place-based partnerships

As already noted, NHS England wants to see, within every ICS, place-based partnerships, which are to lead the detailed design and delivery of integrated services across their localities and neighbourhoods. The partnerships are to involve 'the NHS, local councils, community and voluntary organisations, local residents, people who use services, their carers and representatives and other community partners with a role in supporting the health and wellbeing of the population'. How are these partnerships to be created in Cornwall?

Cornwall's ICB appears not to have given any thought to partnerships except insofar as it has lazily equated them with collaboration among clinician and practitioner members of the in-group. In viewing the world from the standpoint of an in-group, it is automatically dividing the population into two: members of the in-group and outsiders. The in-group, as we see, comprises clinicians and practitioners in the NHS, local councils, and community and voluntary organizations. Local residents, people who use services, and their carers and representatives are outsiders.

To achieve partnership between in-group members and outsiders, the onus must be on clinicians and practitioners to look for ways of bridging the gulf between themselves and outsiders.

The prospects for doing that are not good. Take GPs as an example.

GPs as partners?

General practices are not huge concerns. As the King's Fund succinctly puts it: 'They are small to medium-sized businesses whose services are contracted by NHS commissioners to provide generalist medical services.' So it is reasonable for us to ask: Does the experience of running a small or medium-sized business qualify someone to engage in partnership with local people? On the evidence we have, it does not.

First, the responses to the GP Patient Survey show a significant amount of dissatisfaction among patients with practice arrangements. When only 38% of patients of Helston Medical Centre find it easy to get through to the surgery by phone and only 41% of them usually get to see or speak to their preferred GP when they would like to, there is clearly not a meeting of minds.

Second, we know from data on General Practice websites in Cornwall that only one GP in five works full time at their surgery. Another one in five is a locum who has worked at the surgery for six months or more, and the remaining three in five are listed as part-time GPs. In general, part-time and locum GPs cannot be expected to take on the continuing responsibilities of developing a partnership with local people. Indeed, as the National Association of Sessional GPs puts it, one of the positive attractions of working as a locum is freedom: you are not directly burdened by 'bureaucracy and diktats' and you are free of the responsibilities of running a practice. When you leave the surgery at the end of a session your obligations to the practice and its patients are at an end.

Third, as recent evidence to the Parliamentary Select Committee on Health and Social Care testifies, the demands on the GP workforce today are considerable and complex, with the desire of many to provide continuity of care constrained by a multitude of 'micro-incentives' from the Government to provide particular services. Those who are not planning to retire will find limits on the time and

energy they have available to take on the role of partnership builder in the local community.

Fourth, many practices today are stressful places in which to work. A survey of practice managers carried out by the Institute of General Practice Management in October 2021 found that many were struggling: more than half of respondents had felt unable to take time off for annual leave and almost one-third said they were likely to leave practice management within the next twelve months. Managing a stressful workplace will leave GPs with little energy for partnership building.

Fifth, we have some experience of health system management by GPs, who made up the membership of NHS Kernow, the former Clinical Commissioning Group, now replaced by the ICB. That experience was not a happy one. To take one example: local people were upset by its Governing Body's decision in December 2020 to close the last remaining community hospital in Penwith (Edward Hain hospital in St Ives), where consistently ten of its 11 beds were occupied every night. The result of the closure was and is that residents who have been treated in our acute hospital at Treliske and labelled 'medically fit for discharge' but are not yet fit to go home are being sent to a care home up to 70 miles from their home community. Patients were given no choice of destination: patient choice was 'set aside'.

The CCG's decision to close that hospital was taken partly on the basis of an assurance by Cornwall Council that 28 new care home beds designated as Discharge to Assess (D2A) for patients discharged from Treliske would become available in January 2021. That assurance was not honoured, but the decision was never reviewed. Those beds remained unavailable to Penwith residents during the winter months of early 2021, and were still unavailable in mid-June 2021.

The 28 D2A beds were subsequently reduced to 12; then, in May 2022, KCCG and Cornwall Council agreed with the care home provider that those beds should be 'repurposed' as general nursing beds. The designated D2A beds have been lost. Cornwall Council's assurance has proved worthless. And Penwith is without a community hospital at a time when the chief executive of NHS England has acknowledged that the drive to reduce bed numbers has gone too far: 'We have

passed the point at which that efficiency actually becomes inefficient.' In West Cornwall we have known that for some time.

The task for the Integrated Care System

One important lesson from the work done by New Local and described in their publication *A community powered NHS,* is that to provide fertile ground for partnerships, Cornwall's ICB must forswear its assumptions about 'collaboration'. Many clinicians and practitioners today are tired and disillusioned. The ICB must make a fresh start. It must harness the energies of people who have their roots in local communities, who think outside the box, and who challenge conventional ideas. It could begin by looking to social prescribing link workers, to people who have set up and run food banks, to neighbourhood support groups, to young families and older people living with frailty. It is imperative that the in-group of 'thought leaders' and 'we, the leadership' relax its grip on decision making.

* * *

PS It is known that while some individual attendees at the True North event did express optimism, albeit very guarded, about the new Integrated Care system, they also registered significant concerns, which unfortunately were not mentioned in the report on the event presented to the ICB meeting on July 14th. The failure to acknowledge those concerns clearly does nothing to allay them: rather, it gives them added substance.