Written evidence submitted by British Red Cross. (HCB22).

Overview

This briefing is based on both our experience delivering health and care services across the UK as well as British Red Cross policy research insights. It sets out ways the Health and Care Bill can be strengthened and outlines concerns and opportunities. We hope these inform principled positions during the committee's work.

Summary of British Red Cross position

Overall, we are supportive of the principles of collaboration, reducing inequalities and patient involvement underpinning the Health and Care Bill and welcome the move to formalise a more integrated and collaborative approach by putting Integrated Care Systems (ICS) on a statutory footing from 2022.

Drawing on our experience supporting 82,000 people with health and care needs to live independently at home every year, we know that people's needs are hardly ever only medical. Yet, our system all too often fails to look at the person as a whole. People's housing conditions and finances and feelings of loneliness all contribute to poor physical and mental health, and thereby increase the frequency of people's visits to hospital and their GP.

To address this long-term challenge, the British Red Cross would like to see greater collaboration between health, local government and non-statutory partners, such as the voluntary and community sector (VCS), as well as new powers to inspect the quality of hand-offs between different teams, services and providers so that patient care is prioritised during crucial transitions, such as at the point of hospital discharge. The bill should also turbocharge growing efforts to address the health inequalities that have been so clearly exposed and exacerbated by the pandemic.

Summary of recommendations to strengthen the bill

1. Ensure the bill improves the transition between hospital and home:

a) The bill embeds the 'Discharge to Assess' model, which allows patients to be discharged from hospital more quickly by carrying out ongoing care needs assessments at home (*Clause 78 'Hospital patients with care and support needs: repeals etc.'*). While the model holds great potential, the British Red Cross asks the committee to consider ways to ensure that the current national guidance is turned into statutory guidance and referenced as such in the bill, and that the bill does not unintentionally undermine carers' rights.

b) The bill introduces a positive new duty for the Care Quality Commission (CQC) to review and assess the performance of English local authorities in their delivery of adult social care (*Clause 121 'Regulation of local authority functions relating to adult social care'*). We hope to see the bill introduce new powers for the Care Quality Commission to inspect the quality of hand-offs between different teams, services and providers to improve people's experiences of transitioning between home and hospital.

2. Ensure all aspects of inequalities are addressed and monitored

The bill explicitly references duties for Integrated Care Boards to reduce inequalities with regard to patients' '*access'* to health services and '*outcomes'* (*Clause 12, section 14Z35 'Duties as to reducing inequalities*'). It does not reference patients' '*experiences'* of the health and care system which is a fundamental determinant of good healthcare outcomes. The bill should include an equivalent focus on reducing inequalities between patients' '*experience'* of health services.

3. Ensure the Voluntary Community Sector is integrated into service design and delivery, and strategic development processes

We are disappointed that the bill's integration proposals do not currently extend to the voluntary and community sector (VCS) despite the sector's vast reach and insight into seldom heard communities and potential to reduce inequalities and the quality of care. Duties regarding membership, consultation and involvement in strategy development and service design on both Integrated Care Boards and Integrated Care Partnerships must be strengthened to include explicit requirements to involve the VCS (see Clause 13, Schedule 2: *Integrated care boards: constitution etc*.; Clause 20, section 116ZA (*Integrated care partnerships*); 'Clause 19, section 14Z44 (*Public involvement and consultation by integrated care boards*); Clause 19, section 14Z52 (*Consultation about forward plans*); Clause 20, section 116ZB, subsection 4 (*Integrated care strategies*)).

Concerns and recommendations in detail

1 Ensure the bill improves the transition between hospital and home

Recommendations

1. Seek assurance that the current national hospital discharge policy will be turned into statutory guidance and referenced as such in the bill, that the implementation of the 'Discharge to Assess' model will continue to be supported by dedicated central funding, and that the needs of carers as well as patients are assessed and addressed.
2. Give the CQC formal powers to inspect the quality of transitions between health and social care providers, including at the point of hospital discharge.
3. Give ICBs a responsibility to monitor the extent to which follow-up visits and assessments are taking place after someone leaves hospital, and work with local partners to identify and address ongoing barriers.

Policy and legislative background

Clause 78 *(Hospital patients with care and support needs: repeals etc)* embeds the 'Discharge to Assess' model by allowing patients' care assessments to take place at home after leaving hospital. The British Red Cross welcomed the rollout of the 'Discharge to Assess' model at the onset of the Covid-19 pandemic, which could solve a critical problem to both people and systems, namely that of **delayed transfers of care.** These delayed transfers of care are detrimental to patient recovery, costly for the taxpayer and cause capacity issues in hospitals.

However, British Red Cross and Healthwatch England's research, *590 people's stories of leaving hospital during Covid-19* found that the current model often sees patients discharged from hospital without the right follow up support in place with 82% of patients not receiving a follow-up visit and assessment after leaving hospital, and almost one in five of these patients

reported unmet care needs. Around one in five patients (19%) also felt unprepared to leave hospital. This contributes to slower patient recovery and confusion about accessing follow-up support and risks unplanned emergency readmissions.

The committee should consider amendments that ensure Integrated Care Boards (ICBs) are given a responsibility to monitor the extent to which follow-up visits and assessments are taking place after someone leaves hospital, and work with local partners to identify and address ongoing barriers.

We were pleased to see many of our practical recommendations being incorporated in the most recent 'Discharge to Assess' national policy, *'Hospital discharge and community support: policy and operating model'*, to address these challenges and strengthen the model (including ensuring all patients receive a holistic welfare check when leaving hospital to better determine what pathway a patient should be on and the level of support needed, including non-clinical factors like their physical, practical, social, psychological and financial needs).

To future-proof these positive changes, the committee should consider reforms to the bill that would see current national policy converted into statutory guidance and referenced as such in the bill.

Our joint report with Healthwatch also found that the dedicated funding for hospital discharge provided by government throughout the pandemic has enabled quicker and safer hospital discharges as it removed administrative and financial barriers between hospital care, community health and social care teams. Successive national policy initiatives – that were not supported by dedicated central funding - have previously failed to reduce delayed transfers of care, improve the quality care and improve patient outcomes.

To ensure effective implementation, the government must make sure that the 'Discharge to Assess' model will continue to be supported by dedicated centralised funding.

To enable care assessments to take place at home, Clause 78 repeals the Community Care (Delayed Discharges, etc.) Act 2003 and Section 74 and Schedule 3 of the Care Act 2014, which undermines a carer's right to an assessment. Our position is that the 'Discharge to Assess' model should prioritise assessing and addressing the needs of both patients and carers.

Finally, we know from our work supporting people to leave hospital that every point of hand-off between teams, services and providers is a potential point of success or failure for patient recovery, and that too many people fall through the gaps during these transitions.

The committee should look closely at how patient care is prioritised at the point of discharge, and national policy adhered to, by giving the CQC explicit powers to inspect the quality of hand-offs between different teams, services and providers. Eensuring clear accountability for these hand-offs across a system will need further and urgent exploration.

2 Ensure all aspects of inequalities are addressed and monitored

Recommendations

1. Duties to reduce inequalities between patients should also include a requirement to reduce inequalities between patients' **experiences** of healthcare services (in addition to access and outcomes).
2. Integrated Care Boards should also be required to develop systems to identify and monitor disparities in health outcomes, access and patient experience in order to effectively address health inequalities.

Policy and legislative background

The Health and Care Bill is an important opportunity to turbocharge national commitments to address health inequalities. Covid-19 has highlighted more than ever that where you are born, grow, live and work affects your health, with certain communities, including people from ethnic minority groups and low-income households disproportionately impacted. Pervasive health inequalities produce worse health outcomes for some demographic groups. For instance, men living in the most disadvantaged communities in the UK can expect to live for 9.5 years less and women 7.5 years less than those living in the wealthiest areas.[2]

Clause 12, section 14Z35 (*Duties as to reducing inequalities*) introduces a new duty for Integrated Care Boards 'to have regard to the need to reduce inequalities between patients with respect to their ability to access health services (a) and with respect to the outcomes achieved for them by the provision of health services (b)'.

We welcome these provisions but ask that the committee seeks to strengthen them further by adding a third element, namely 'to reduce inequalities with respect to patient experience of health services'.

Soon to be published research by the British Red Cross shows that the high intensity use of A&E is closely associated with deprivation and other disadvantages including physical and mental health problems, social difficulties, and often negative experiences of care elsewhere. While only 0.67 per cent of the English population attend A&E frequently (from 5 to more than 300 unplanned visits a year), as a group they are significantly over-represented in emergency care, accounting for 16 per cent of all A&E attendances, 29 per cent of all ambulance journeys and 26 per cent of all admissions in England. Our research estimates the cost of the high intensity use of A&E at £2.5bn per year to the NHS.

A common thread across these patients' experiences is their difficulty navigating health and care services and their perceived negative treatment by healthcare staff. People often don't feel listened to, understood or, in some instances, feel stigmatised. These experiences can result in disengagement from healthcare services, an escalation of needs and repeat acute interventions. **Incorporating 'experiences of care' in the ICB's duty to reduce inequalities could help to address this issue.**

3. Ensure the VCS is service design and delivery, and strategic development processes

Recommendations

1. The Bill's integration proposals must be strengthened to include duties on Integrated Care Boards and Integrated Care Partnerships to co-operate and involve health-related partners from the voluntary and community sector.

Policy and legislative background

Voluntary Community Sector organisations provide critical services across health and social care and are well-placed to support better outcomes for patients and communities through both strategy and service design and delivery in a cost-effective way. They are often more likely to be trusted by seldom heard communities and bring valuable insights about hidden vulnerabilities. Their involvement in both service delivery and strategy development is therefore crucial in delivering key components of the bill, such as reducing health inequalities, improving the quality of services and strengthening patient involvement. We were pleased to see NHS England and Improvement's design framework for ICSs recognise the role of the VCS and recommend its involvement in strategic decisions. We would like to see the same recognition and role of the VCS with regards to ICSs in the bill.

The committee should consider amendments that ensure Integrated Care Boards and Integrated Care Partnerships are required to consult and involve VCS organisations supporting and representing communities with the worst health outcomes in their area when planning commissioning arrangements (section 14Z44), developing their forward plans (section 14Z52) and strategies (section 116ZB, subsection 4).

No one part of the system can achieve the ambition of improving population health and reducing health inequalities without taking a truly cross-sector approach. The **most effective interventions recognise the range of clinical and non-clinical needs** people have, beyond their immediate health condition or illness.

Current levels of collaboration between ICSs and the VCS are mixed with many healthcare decision-makers, commissioners, and healthcare staff unaware of the complementary and valuable strategic insights and wrap-around services delivered by the VCS. However, neither Clause 13, Schedule 2 (*Integrated care boards: constitution etc*.) which stipulates the membership and constitution of ICBs, or Clause 20, section 116ZA *(Integrated care partnerships*), which stipulates the membership of ICPs, currently include health-related partners, such as the VCS. The Government can address this knowledge gap by ensuring VCS representation in both ICBs and ICPs membership.