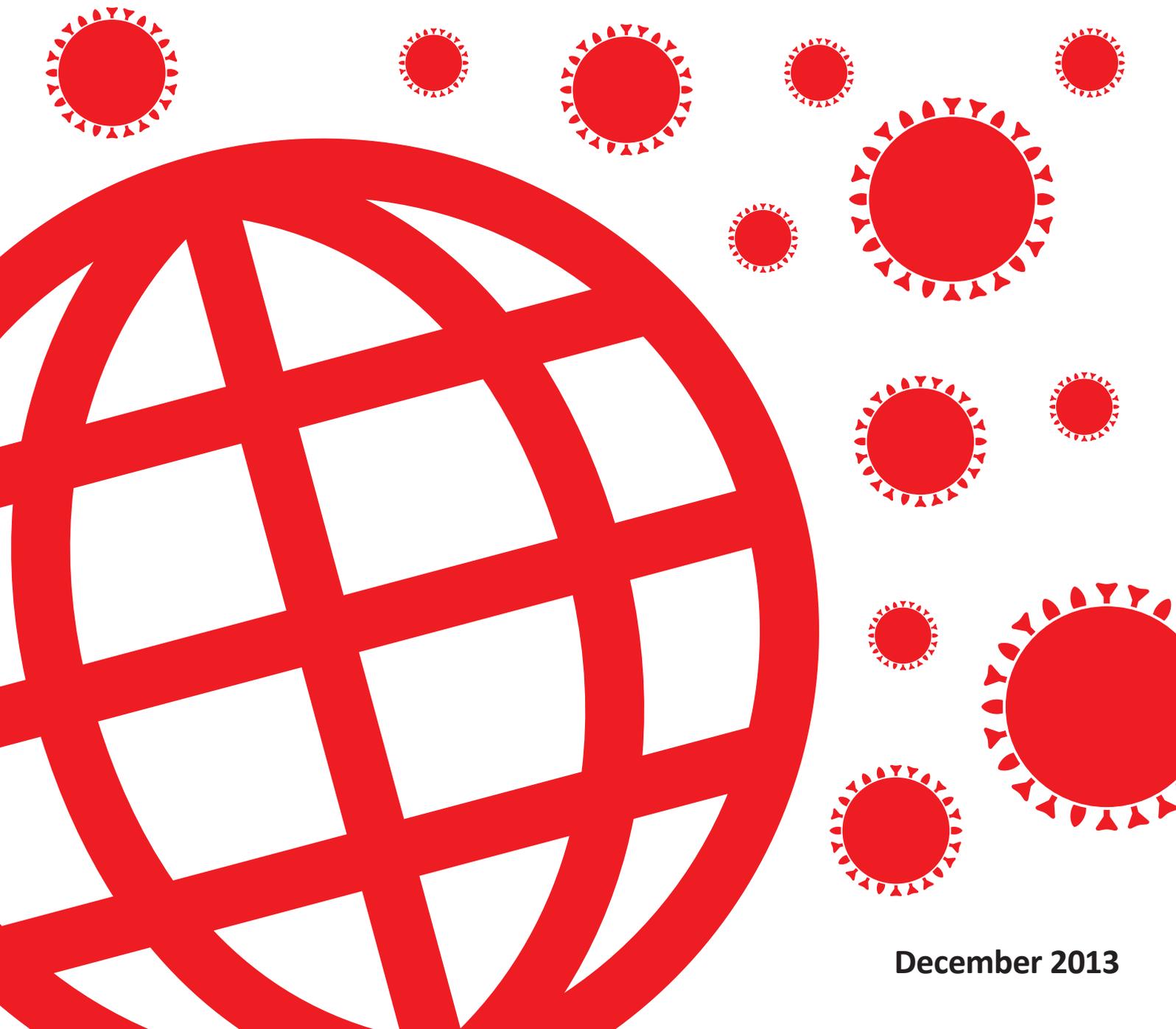


# Getting behind the Curve? Is the new NHS ready for Pandemic Flu?



**The Centre for Health and the Public Interest (CHPI) is an independent non-party think tank aiming to set out a vision of health and social care policy based on accountability and the public interest.**

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## Executive Summary

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1. The top risk on the UK Civilian risk register is pandemic flu, which the government considers may well happen in the next 5 years.<sup>1</sup> Since the last flu pandemic in 2009 wholesale changes have been made to the structures of the NHS and public health in England as a result of the Health and Social Care Act (HSCA) 2012. This report considers the ability of the new NHS and the wider public health system to respond to this threat. It examines three potential problems:
  - The effects of re-organisation - the loss of expertise, personal relationships and institutional memory from within the system.
  - The lack of clear accountability arrangements and a 'clear line of sight' under the new system.
  - The co-ordination of increasing numbers of private providers of NHS services in a health care system underpinned by contracts.
2. The report finds that in a major pandemic the newly reorganised NHS in England is likely to face extra challenges. In part, this is an inevitable consequence of the disruption caused by such a major re-organisation. In a pandemic, when there will need to be clear lines of communication and responsibility, with the centre having capacity to direct personnel and healthcare resources towards areas of greatest need, there is instead fragmentation and a lack of clarity within the newly-created organisational structures about who does what and how the system is co-ordinated. The potential problems stretch from the top, with an ill-defined role expected of the Chief Medical Officer, through confusing multiple and parallel structures embracing the NHS, Public Health England and local government, right down to the front line with its increasing number of private providers.
3. In general, a market-driven health care system underpinned by a series of contracts is ill-suited to the demands of a major health crisis because it prioritises efficiency savings, patient choice and competition between healthcare providers over centralised planning, and seeks to minimise spare capacity in hospitals and other health care facilities. Requiring contracted healthcare providers to act appropriately in an emergency is also extremely difficult, as they will be expected to deliver services in unforeseen circumstances not specified in or funded through their contracts. Exceptional powers of direction over the NHS are granted to the Secretary of State under the HSCA 2012 to deal with such an emergency – in effect implying a suspension of the operation of the healthcare market and normal day-to-day-operational arrangements. However, these powers are unlikely to overcome the basic defects of a fragmented system and they remain untested and hence uncertain. The report concludes by suggesting some short-term fixes, but these can only partially compensate for the basic problems identified.

## Introduction

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4. Pandemic Flu has headed the national civilian risk register for some time.<sup>2</sup> Swine flu (H1N1) in 2009 was a much milder strain of the disease than many had feared but still left many dead and some NHS services stretched. The next time, and as the government suggests there will be a next time, the flu strain could be more deadly.<sup>3</sup> The next pandemic could arise from H5N1 ('bird flu') or H7N9, or, like swine flu, come from elsewhere. When it comes, there may be only a few weeks' warning before there are significant numbers of cases in the UK. The question is, is the new system ready?
  
5. There was a great deal of preparation in anticipation of bird flu in 2007 and much of the guidance issued then has subsequently been revised in the light of the experience of swine flu. The current national policy for the health response to pandemic flu was published in 2011, after public consultation.<sup>4, 5</sup> A further revision is taking place now, but it is understood that the basic policy is unchanged. Here we are not examining that policy as such but instead the practicalities of it being delivered in 2013 through the new structures of the NHS and public health. The NHS in England is emerging from a major re-organisation with roles and responsibilities for day-to-day tasks still evolving.<sup>6</sup> Using the key elements of the experience of 2009 and the latest national pandemic plan, this report asks how far the architecture of the new health system in 2013 is capable of dealing with a flu pandemic. Pandemic flu has been chosen because of its prime position on the national risk register, but many of the same issues would be raised by any other sustained crisis affecting the population's health.

## Background

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- a. *The importance of knowing who is in charge and having a ‘clear line of sight’ in major emergencies***
6. Clarity about responsibilities and a ‘clear line of sight’ is important for the officials who have to co-ordinate and deliver a response to a major emergency. It means that directions can be conveyed from the centre of the system to the periphery with ease, and with confidence that they will be followed, whilst information from the front line can be reliably sent back to the centre. When demand for health care services overwhelms the local ability to respond, as occurs in many types of emergency, an agreed and centrally co-ordinated system allows the centre to ensure that aid is brought in from less-affected areas. Clear accountabilities in command and control - as a fundamental of health protection - also chimes with the Cabinet Office’s 8 guiding principles for response and recovery in a major emergency, derived from a combination of international best practice and learning from past events.<sup>7</sup>
7. There is a general expectation that in a pandemic the sheer volume of those infected will overwhelm the health care system and so decisions will need to be taken by politicians on the rationing of resources and the co-ordination of healthcare facilities and personnel, based on the advice of independent scientists and people with medical expertise and training. Clear arrangements for command and control at national, regional and local levels are needed in order to facilitate the optimum response from the system as a whole.
- b. *The NHS structure at the time of the swine flu outbreak in 2009***
8. At the time of the last flu pandemic, in 2009, 3-4 years had elapsed since the last reorganisation of the NHS, and the public health system and roles and responsibilities within the health system as a whole were fairly well established. The top team at Department of Health (DH), including ministers, could issue clear advice to the field – hospitals, GPs and other care providers – with the expectation that what came to them in firm guidance would be followed, and would be policed by the Strategic Health Authorities (SHAs). The local commissioning purse-strings were held by Primary Care Trusts (PCTs), while the SHAs were able to balance out the budgets between them, using if necessary surpluses from elsewhere.
9. Foundation Trusts, while nominally independent of SHAs, were expected to comply with any directions issued from the DH along with other acute hospital trusts. GPs and other independent contractors were overseen by the PCTs for their primary care functions. Whilst the Health Protection Agency (HPA) had been established outside the NHS structure – which created a number of difficulties in terms of co-ordination – it was consolidating its role as health protection advisor to the wider system, including on matters such as

communicable disease outbreaks. In addition, public health expertise existed at all levels of the NHS, with medically trained Directors of Public Health (DsPH) sitting in both Primary Care Trusts and in Strategic Health Authorities.

### ***c. The health response to the swine flu outbreak in 2009***

10. When the swine flu pandemic emerged in spring 2009, the various aspects of the response highlighted in the first column of Table 1 were dealt with by the organisations in the second column.
11. The UK response to the strategic aspects was reviewed by Dame Deidre Hine.<sup>8</sup> Whilst the general public's view, and indeed the view of many in the NHS, was that the central response to swine flu was excessive and an over-reaction, as a 'dummy run' for a severe pandemic the response provided lessons that can be used for the future.<sup>9</sup>
12. During the 2009 pandemic, the policy on how to respond was formulated at the centre, with the Government Chief Scientific Advisor (GCSA) and the Chief Medical Officer (CMO) for England playing key roles. Politicians and civil servants had access to independent scientific and medical advice when taking crucial decisions, such as whether to recommend school closures and to whom to distribute anti-virals. The Health Protection Agency (HPA) provided advice at all levels within the NHS, and led on the detection of flu cases through its laboratories and its local communicable disease control consultants, and provided regular assessments of the nature and prevalence of the disease. A national campaign of health education was run, with the 'catch it, bin it, kill it' slogan used in advertisements. PCTs were charged with ensuring that their local populations were able to get access to antiviral drugs – which were expected to ameliorate the severity of symptoms – within 48 hours of the symptoms' first appearance, if necessary using a novel delivery system of Antiviral Collection Points (ACPs) based in community settings, including local pharmacies.
13. The NHS Direct phone line service provided advice to the public throughout, and the DH also asked it to set up a National Pandemic Flu Service (NPFs) to oversee approval for antivirals. Prior to the establishment of the NPFs, PCTs were expected to assess the appropriateness of individuals for antivirals as well as distribute them. Local Directors of Public Health and their teams proved key to the performance of both these functions.
14. The Strategic Health Authorities (SHAs) ran their usual intelligence system of gathering and analysing 'sitreps' (situation reports) from the field, and also cascaded down the frequent instructions and guidance from the centre.<sup>10</sup> Plans for enhancing the 'surge capacity' in clinical services were not fully tested, since the peak of swine flu was reached during the summer of 2009 when general pressures on the health service were less than those often experienced in winter. Major problems in providing services were experienced only in areas of specialist hospital practice, such as critical care and especially intensive paediatric care. Social care providers experienced less demand than they might often experience during the winter.

Table 1. Lead areas for pandemic flu response and changes 2009 to 2013			
Area/role	Who in 2009?	Who in 2013?	Comment on 2013 situation
<b>Overall national strategy/lead</b>	Chief Medical Officer (CMO)/ Government Chief Scientific Advisor (CSA) advised by Scientific Advisory Group for Emergencies. (SAGE) Advice from Health Protection Agency (HPA) to CMO. Direct route from DH/ Secretary of State (SoS) to the NHS (PCTs and Trusts).	Central policy formulation as before, but with potential external challenge group. SofS line to the NHS now via the mandate to NHSE.	CMO no longer in direct line of sight to HPA/Public Health England. No NHS/social care voice at top table. No direct route from DH SofS to NHS front line, except through untested emergency powers.
<b>Whole of society response</b>	Cabinet Office, Local Authorities, Local Resilience Forums, businesses.	As before, but learning expected to improve performance from 2009.	Increased impact of social media. Directors of Public Health with more direct influence in Local Authorities.
<b>Public information</b>	Department of Health with 'catch it, kill it, bin it' campaign. NHS Direct for personal phone advice through the National Pandemic Flu Service.	Department of Health for national campaign. 111 for personal phone advice.	111 phone services under stress and not judged to perform to the standards of NHS Direct, also lacking versatility and clinical involvement.
<b>Detection and assessment of the disease.</b>	HPA, central and local teams.	PHE, essentially the same HPA teams as previously.	Unclear who provides logistical support to local PHE teams, eg for sampling, previously provided by PCTs.
<b>Antivirals</b>	National Pandemic Flu Service (NPFS) phone line run by NHS Direct with PCTs running Anti viral Collection Points (ACPs) to distribute drugs from DH stockpile.	PHE responsible for the antiviral stockpile; NHSE commissioning NPFS phone line and local distribution.	The residual NHS Direct may not have capacity to take on the NPFS. There may be a vacuum before NPFS can be established, which was previously filled by PCTs. Increased and more open scepticism on the value of antivirals amongst medical community and the public.
<b>Primary (medical) healthcare</b>	GPs and their practices, supported by PCTs. Standard Out of Hours (OOH) arrangements.	As before, GPs and their practices, supported by NHSE Challenges with capacity including performance of Out of Hours GP services. GPs now undertaking commissioning role in Clinical Commissioning Groups.	GPs, based in CCGs, may revert to their clinical roles leaving a gap in the commissioning function. Out of Hours services may not be sustainable in a pandemic.
<b>Secondary healthcare</b>	Hospital services for (a) those with flu and (b) all other diseases. Strategic Health Authority (SHA) oversight.	Hospital services as before, with NHSE taking over the SHA role.	NHSE smaller than the PCTs/SHAs they replace, so may not have the capacity for the task. Questions over the powers to require providers to undertake exceptional activity.

## Problem 1: The effects of re-organisation - the loss of expertise, personal relationships and institutional memory from 2009 to 2013

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15. When considering the preparedness of the UK health system for future crises the World Health Organisation (WHO) suggested in 2011 that the Department of Health 'may consider taking action to ensure, in view of the rapidly changing topography of the health service, the maintenance and strengthening of corporate knowledge and interorganizational collaboration, as well as the maintenance of effective multi-agency command and control arrangements'.<sup>11</sup>
16. However, none of the agencies which existed in 2009 (PCTs/SHAs/HPA and NHS Direct) and which co-ordinated the response to flu then is now in existence (NHS Direct survives as a provider of some 111 services, but not for long). Such a massive change in the architecture of the health system will undoubtedly have an impact on its ability to respond to a major crisis. As the Institute for Government notes, it takes over two years for an agency to recover after an entire system or major re-organisation.<sup>12</sup>
17. In addition, there has been loss of expertise and institutional memory as a result of qualified staff leaving. Many previous Directors of Public Health (DsPH) did not transfer to Local Authorities as expected and only 4 in 5 Local Authorities had a substantive DPH in post by August-October 2013. Both NHS England and Public Health England were slow in filling posts. Virtually no public health professional previously employed in the NHS will now have the same employer as previously. Across the entire system around 10,000 staff were made redundant.<sup>13</sup>
18. Those who hold posts important for managing an emergency response are often newly appointed and have yet to work on the personal relationships which are crucial to dealing with an emergency. They may not even be able to access readily the 'lessons learned' from past outbreaks or public health emergencies, since websites and archived documents were lost as organisations were disbanded.
19. Taken together these factors mean that responsibility for responding to a major emergency – which could happen at any time – now rests with newly created organisations which are short of institutional memory and in which inter-personal links and networks have been significantly disrupted as a result of the changes to the NHS.

## Problem 2: Confused accountabilities and the lack of a ‘clear line of sight’ under the new arrangements

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20. The structure envisaged in the Health and Social Care Act 2012 have been in place since April 2013. It has proved to be an excessively complex system: according to one commentator ‘any attempt to draw an organogram of how the English health system is now meant to operate is a serious challenge’.<sup>14</sup> In terms of the health protection response, there is now a tri-partite structure: the DH, with the new body Public Health England; the NHS; and Local Authorities, which now include the local Directors of Public Health.

Taking each in turn:

### *i. Public Health England*

21. Public Health England (PHE), an executive agency of the DH, includes the functions of the previous Health Protection Agency. As with its predecessor, the role of PHE is essentially advisory, and like the HPA it remains separate from the NHS.<sup>15, 16, 17</sup> It continues to provide the laboratories and other functions required for leading the monitoring and surveillance previously provided by the HPA. However, questions remain over how it will obtain the local operational support it will need, since this came previously from the now-abolished PCTs.<sup>18</sup>
22. It is important to note that PHE carries no direct responsibility for the day-to-day functioning of the NHS or the costs to others of what it recommends. It will be judged mostly on the numbers of infections and deaths that occur as a result of flu, and how the measures it recommended did or did not influence these. It is a hierarchical organisation with little scope for local dissent: sometimes local circumstances suggest some flexibility would be appropriate.<sup>19</sup> Questions arise about the level at which any scientific disagreements may get dealt with, and whether the practicalities of being able to deliver NHS health and social care will always get adequate consideration in any recommendations made.

### *ii. The NHS*

23. NHS England (NHSE) is responsible for allocating the vast majority of NHS funding and according to its agreed mandate is accountable to DH Ministers. Teams from NHSE at various national, regional and local areas commission services direct from specialist providers and primary care independent contractors, and provide funds for Clinical Commissioning Groups (CCGs) led by GPs. It has a ‘central support unit’ and operates out of 27 local area teams, but is expected to rely on PHE for public health expertise.

24. CCGs, which are overseen by NHS England, are supported by commissioning support units (CSUs) to help them to commission the majority of the secondary health services needed by their patients, and also the 111 phone advice service, ambulance services, Accident and Emergency and out of hours primary care services.
25. Prior to April 2013, when concerted national action was thought important, DH ministers could issue directions to NHS Trusts, and Foundation Trusts were expected to comply. It is unclear if the routine powers now exercised by NHSE on behalf of DH would permit such instructions to be issued, or indeed even to exercise the untested powers that are envisaged in an emergency (see box 1).

### **Box 1: Emergency powers of Direction on the NHS**

- The Secretary of State's emergency powers can be used, and delegated to NHSE, under sections 46/47 of H&S Act 2012, with no explicit definition of what the scope of these powers is.
- Guidance explains: "In extreme circumstances such as pandemic influenza, a national fuel shortage or extreme weather, the NHS England national team may take command of all NHS resources across England".<sup>20</sup>
- These powers could apply to any provider in receipt of NHS funds [s47 (3)]
- The powers to direct relate to either providing or ceasing to provide any services for the purposes of the health service [s47 (4)]
- This differs from the provisions contained within the standard NHS contract, which are limited to the types of activity the NHS provider/supplier usually provides.<sup>21</sup>
- There is no precedent for such use of NHS emergency powers, nor has it been subject to planning exercises.
- There is no guidance on what the exercise of these powers might mean for contracted NHS providers, e.g. for the transfer of liability or for reimbursement in an emergency.
- It is unclear whether the emergency powers would stretch to subcontractors.

26. A persisting weakness of the NHS is the lack of command and control in practice over independent contractors such as GPs and other independent providers. Not fully tested in the mild 2009 pandemic, in future this might apply, in particular, to policies over which there is no professional consensus, such as the use of antivirals (about which there is increasing professional scepticism).<sup>22, 23</sup>

### **iii. Local Authorities**

27. Local Authorities carry the main burden of responsibility for the public health of the local population. The Health and Social Care Act left unchanged the existing responsibilities of local authorities for health protection, social services and emergency planning, but gave them some additional functions relating to public health that came with the transfer of Directors of Public Health from the old PCTs to local authorities. However, the bonus of bringing public health expertise to local authorities in the persons of the Directors of Public Health may not compensate for their loss of influence on the NHS when dealing with an emergency. The local DPH, previously a director in the PCT, is now based in the local authority. The official position as set out in recent guidance is that “This ...role in health protection planning is not a managerial, but local leadership function. It rests on the personal capability and skills of the local DPH and their team...”<sup>24</sup> The DPH thus faces having considerable responsibility without authority and is not surprising that the public health community has persistently been one of the greatest critics of the new arrangements.<sup>25, 26, 27</sup>

#### ***How will the tri-partite structure join up at local level?***

28. As a general rule, the more that administrative boundaries between different organisations coincide geographically the easier it is to co-ordinate a response to a crisis. Unfortunately, the administrative map of the NHS and the corresponding health protection functions is now one of significant overlap and confusion. There are 150 local authorities, each expected to have a Director of Public Health, though some are shared and some vacant; 212 Clinical NHS Commissioning Groups; 15 regional centres of Public Health England; 27 local area teams of NHS England; and 38 police boundaries, which means 38 Local Resilience Forums (LRFs), the basic units of emergency planning more often used to dealing with one-off acute events.
29. London’s problems are compounded by some key roles relating to emergency planning being held by the Mayor, as well as by the presence of a large number of acute providers. As a well-informed group of commentators has noted, “The NHS reforms have created a much larger number of organisations in London and their purposes are not always well aligned; the risks of incoherence and inconsistency are high.”<sup>28</sup>
30. At a practical level, this means that DsPH and local PHE units may cover more than one local authority and relate to several clinical commissioning groups (CCGs), adding to the complexity of the arrangements. NHS providers such as hospitals, which will be first responders in an emergency, can also serve several CCGs. Whatever the rationale for the current structure it is highly unlikely that this arrangement was put in place with a public health emergency in mind. The mechanisms for joining up this system on the ground are Local Health Resilience Partnerships (LHRPs). These are ‘the forum at the LRF level for developing and testing joint health sector response plans’, but are yet another grouping dependent on assumed rather than specified duties of collaboration.<sup>29</sup>

As noted by the Faculty of Public Health (the standard-setting body for public health professionals in the UK), ‘lead directors of Public Health who co-chair LHRPs will need to secure agreements for actions across multiple Local Authorities but will not have direct management of resources.’<sup>30</sup>

### ***Reporting to the centre and driving the response to a pandemic across the system***

31. As a result of the movement of public health generalists (DsPH) out of the NHS into local government, and the continued separation of health protection specialists in another non-NHS organisation (PHE), there are now potentially 3 parallel structures of command:
  1. Department of Health and Public Health England;
  2. NHS England, CCGs and both NHS and private providers of NHS health services;
  3. Department of Communities and Local Government and Local Authorities with Directors of Public Health.
32. Although a clear hierarchy of authority exists between the DH and Public Health England, the same cannot be said of the other two structures of command. Now that so much of the day-to-day operation of the NHS has been transferred to an independent arms-length-body, NHS England, there is significantly less capacity within the Department of Health to direct the way NHS care is arranged and provided. There is also a political commitment on behalf of the current Ministers to stay out of the running of the NHS; yet the stability of these accountability arrangements, particularly when the NHS comes under pressure, remains to be seen. And as for the DCLG and Local Authorities, local authorities have always cherished their independence from central government and their DsPH may be expected to follow suit.
33. Relationships between these 3 hierarchies have also, it seems, yet to be worked through in detail. For example, a recent circular explaining the arrangement for protecting the health of the local population, came from DH/PHE and the Local Government Association, without including NHS England as an author.<sup>31</sup>
34. In addition, the role of the Chief Medical Officer has changed substantially since the last pandemic, not thanks to the HSCA alone, to the point where he or she will have no direct control over either Public Health England or NHS England, or even the central policy team in the DH (see Box 2). In addition DsPH no longer fall under the DH’s direct influence. Thus the fundamental weaknesses in command and control down 2 of the 3 hierarchies are not compensated for by strong and formal links between them, at any level.

***Box 2: Central pandemic flu policy and the role of the Chief Medical Officer (CMO)***

- The CMO is expected to be the cross-government lead for public health emergencies such as pandemic flu
- According to the government's plans 'The CMO with Public Health England will provide the Secretary of State with consolidated health advice to inform response and recovery'.<sup>32</sup>

But:

- The CMO is no longer responsible for medical advice to the NHS (but only to the Secretary of State), a cause of some concern.<sup>33</sup>
- The CMO no longer has Public Health England reporting directly to her.
- The CMO no longer has the DH flu policy team reporting directly to her.
- The CMO no longer has a budget.<sup>34</sup>
- Hence, it is unclear how the CMO could rely on the support she would need for the onerous role expected of her during a pandemic, including ensuring advice is well-informed, pragmatic and credible to the field.

## Problem 3: Co-ordination of increasing numbers of private providers of NHS services under a market-based health care system underpinned by contracts.

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35. As a result of the Health and Social Care Act the healthcare services needed to care for those infected in a pandemic will in the future be increasingly provided by for-profit providers under contracts with CCGs and NHS England. In 2012, around 10% of what PCTs spent on NHS care was already being spent buying care services under contracts with the private sector.<sup>35</sup> Community health services in some parts of the country are being transferred to the private sector under multi-million pound contracts and a private company is currently running an NHS acute hospital, including Accident and Emergency services.<sup>36</sup> In addition, the vast majority of social care services are run by for-profit companies.
36. Yet for a number of reasons market provision of healthcare services, governed by contractual arrangements, is ill-suited to public health emergencies that occur irregularly. First, the nature of the contracts which exist between the NHS and the private sector cannot be effectively written to cover all the relevant contingencies: to anticipate and cover everything would mean adding to the current contracts a wide range of shadow embryo contracts for many potential eventualities. The NHS standard contract for acute hospitals for 2013/14 seeks to require providers to have an emergency plan in place and requires them to deliver an enhanced response, but appears not to have any scope to require them to do anything not specified in the contract, which is what could be required in an emergency.<sup>37</sup>
37. Second, in order for a market in healthcare services to operate effectively and deliver the 'efficiencies' which result from competition, it is likely and common for some providers to fail and go out of business. The government acknowledged this in the impact assessment on the Health and Social Care Act and a number of NHS Acute Hospital trusts as well as private providers of care services, in particular residential care services for older people, are currently facing administration.<sup>38</sup> Whilst the government has put in place arrangements to ensure 'continuity of provision' for healthcare services, an effective emergency planning system relies on a continuous and reliable supply of health care resources which are not facing the distraction of fending off financial collapse.
38. Third, the 'surge capacity' in hospital and community services – such as the ability to provide extra beds in intensive care units, or staff at walk-in centres, which is critical to being able to respond to a major emergency - cannot

be delivered easily by a market-based system, as the US healthcare system demonstrates. This is primarily because there is no incentive structure for excess capacity within the system. Indeed, excess capacity is seen as a costly inefficiency. Where surge capacity is provided under a market-based system this may have significant financial consequences for healthcare providers, which is bound to affect their willingness to provide necessary services without guarantees of financial reward.<sup>39</sup> A major US government-funded study into how hospitals prepared for 'surge capacity' found that working in a competitive market meant that some providers were reluctant to share bed data with competitors, even during a disaster.<sup>40</sup> In the English NHS, hospitals are only paid 30% of the normal payment for excess emergency admissions meaning that a sustained shift from routine to emergency work in a pandemic would not be financially viable for any length of time.<sup>41</sup>

39. The weaknesses of the market model are felt most of all in social care, with market failures likely and experienced regularly.<sup>42</sup> There is little public sector capacity left to help pick up the pieces, for example when a major provider of care homes collapses, and zero-hours contracts provide added insecurity over the deliverability of contracts. In addition, volunteering in social care could well be inhibited by the dominance of for-profit providers.

## Conclusions

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40. The changes brought about by the HSCA have been extremely disruptive. The NHS is already struggling to deliver on the 'day job' of routine emergency admissions, so would be exceptionally challenged by a crisis such as a flu pandemic. At such a time, limited resources will need to be used to maximum effect, with good co-ordination between local authorities and the NHS in particular. Instead, we have too much uncertainty combined with a lack of appropriate skills and organisational memory.
41. There appear to be new difficulties from top to bottom, from central policy-making, through loss of expertise resulting from the substantial staffing and organisational changes caused by the re-organisation, down to the ability to deliver at local level. The CMO and local Directors of Public Health, who are expected to have key roles, are outside any formal accountability lines relating to those leading the health service response (NHS England) or those advising on it (Public Health England). Hence the expected emergency response is not 'grounded in existing functions of organisations and familiar ways of working', as would be expected good practice, and as called for by the Cabinet Office.<sup>43</sup> There are parallel structures with uncertain arrangements between them, and much accountability for unexpected crises is based on the least secure arrangements, backed by goodwill.
42. Even when the new system beds down and accountabilities are mutually agreed, a clear line of sight may still prove more difficult to achieve, and command and control cannot be easily exercised in a system increasingly determined by the market – two elements regarded as of key importance to emergency planners. This affects both the ability to direct the system as a whole and to collect and utilise the intelligence needed to do so. A market-based system does not reward resilience and so is ill-prepared for sudden and exceptional events, putting in question our reliance on increasing numbers of private providers. There are too many new problems for comfort.

## How can these weaknesses be overcome?

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### **Clarify accountabilities within the current system**

43. Lack of formal accountability arrangements can be overcome at a local level, but it takes time and the right personalities, joint exercises, and probably a few real challenges too. In a few years local fixes may well be devised so that everyone knows who will do what in the event of a pandemic. But we may not have time for this before the next inevitable re-organisation, and this acts as a disincentive for those expected to devote effort to making broken systems work in the meantime.
44. The revised national pandemic flu guidance expected in the coming year must find a way through the current confusion, clarify responsibilities, and preferably devise a single organogram that includes all the key agencies and has the same interpretation by every party. If the CMO is to be the lead professional advisor and the main media representative or 'talking head' during a pandemic flu response, as was the case last time, it is important that she is supported in that role by staff reporting directly to her and having sufficient resources and budgets. Since poor communication between agencies is a constant challenge in a crisis under any system, regardless of how well-designed things may look on paper, this will need special attention in 'dry-run' exercises to test the system's capabilities.

### **Clarify the Secretary of State's emergency powers to direct during a pandemic and clarify arrangements for those expected to provide surge capacity.**

45. If the emergency powers of direction on the NHS (outlined in Box 1) are thought to be the solution to the problems of co-ordination in a pandemic, then there needs to be much more clarity over how these powers would be used in practice, including when they may be enacted and what types of directions will be issued, with some realistic testing. The payment and indemnity arrangements for providing surge capacity also need to be agreed with private sector providers in advance.
46. In addition, with so many essential services now being delivered by private companies and their subcontractors, more attention will need to be paid to the inclusion of emergency preparedness in sub-contracts. Due diligence in

contracting should cover all aspects of provider resilience in a crisis, including the financial strength of the organisation, and should go beyond requiring providers to have business continuity plans in place. The financial difficulties of the previous provider of the National Pandemic Flu telephone services, NHS Direct, is an example of the importance of this.<sup>44</sup> This works all down the line to the most mundane support services – after all the slogan ‘catch it, bin it, kill it’ implies that there is someone to empty the bins. In this respect, it may need to be accepted there is a financial price to be paid under a market-based system for building resilience and the potential for ‘surge capacity’ into it, since doing so would have significant benefits during a flu crisis, and no doubt also prove useful in other crises, such as an exceptionally severe winter.

## Consider building more health protection and public health expertise into NHS England.

47. In a major crisis, when everyone has far too much to do, it is not unreasonable to expect people to concentrate on the core business of their own organisation, following instructions of their own line manager and delivering the outcomes on which their organisation will be judged. This creates a general problem when so much of the delivery of the pandemic flu response depends on goodwill and the dotted lines in organograms, and a particular problem for NHS commissioners and providers who will have to rely on expertise which exists in other bodies. To address this, NHS England’s 27 local area teams might find it necessary to appoint more of their own experts to lead on items like pandemic flu, rather than relying on PHE or Local authority-based public health teams who will be responding to their own organisational demands and which may make them unable to assist the NHS response effectively. This will have added costs.

## Temper the market system

48. There are political choices to be made over the relative priority to be given to systems that appear to offer maximum efficiencies during times of relatively predictable and routine demand for healthcare, and those that have more resilience when the going gets tough, such as in a pandemic. Even with optimum lines of communication and command and control, a market-based system has fundamental weaknesses for the handling of sudden crises. This can be ameliorated to some extent by good planning. Some advance investment may be costly, but other preparation may be less so, for example consideration of how best to mobilise a supplementary and volunteer workforce to help keep sick elderly people out of hospital.
49. Pandemic flu may be the extreme challenge for social care and the NHS, but it heads the national risk register for a good reason. The systems generated by the HSCA have left new vulnerabilities that will need to be rectified, much of it, we suspect, by non-market cross-system collaboration.

## List of abbreviations

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<b>ACP</b>	Antiviral Collection Points
<b>CCA</b>	Civil Contingencies Act
<b>CCG</b>	Clinical Commissioning Group
<b>CMO</b>	Chief Medical Officer
<b>CSU</b>	Commissioning support Units
<b>DCLG</b>	Department of Communities and Local Government
<b>DH</b>	Department of Health
<b>DPH</b>	Director of Public Health
<b>GCSA</b>	Government Chief Scientific Advisor
<b>HPA</b>	Health Protection Agency
<b>HSCA</b>	Health and Social Care Act 2012
<b>LA</b>	Local Authority
<b>LHRP</b>	Local Health Resilience Partnership
<b>LRF</b>	Local Resilience Forum
<b>NHSE</b>	National Health Service England
<b>NPFS</b>	National Pandemic flu service
<b>OOH</b>	Out of Hours
<b>PCT</b>	Primary Care Trust
<b>PHE</b>	Public Health England
<b>SAGE</b>	Scientific Advisory Group for Emergencies
<b>SHA</b>	Strategic Health Authority
<b>WHO</b>	World Health Organisation

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