Eight key questions on the 2019 NHS legislative proposals

Nuffield Trust submission to the Health and Social Care Committee

The Nuffield Trust is an independent think tank which aims to improve the quality of health care in the United Kingdom by providing evidence based analysis. This submission aims to provide a set of questions which will be useful to the Committee as they conduct pre-legislative scrutiny of the proposals published by NHS England on the 28th of February.

These do not represent a comprehensive analysis of the proposals, but rather focus on key issues where more clarity or additional measures might be helpful. They address not only the specifics of the proposals, but also the context, shaped by NHS England’s Long Term Plan, in which they are intended to take effect.

1. **What areas will be covered by the new Integrated Care Systems, and will they work?**

Section 6 and 8 of the proposals would lay the legal underpinning for Integrated Care Systems (ICSs) to become a defining unit of the NHS. But what areas will these cover?

The Long Term Plan suggests ICSs will grow out of the 44 Sustainability and Transformation Partnerships (STP) that cover England¹. But boundaries drawn for some of these partnerships are unlikely to work well as the basis for a permanent organisational unit.

Some make obvious sense and reflect transport and patient flows. Others are not so logical and seem to have been determined by the need to address issues of acute trust configuration. STPs such as Cheshire and Merseyside; Hertfordshire and West Essex; and Bath, North East Somerset, Swindon and Wiltshire do not map to one natural community but rather combine bits of several, with patients being referred out to different specialist hospitals. They cut across systems, rather than uniting them.

It may be sensible to set more explicit criteria for the shape of ICS based on the natural flow of populations. An argument against this might be that there has already been too much investment in the current footprints to warrant unpicking them. In that case there will need to be arrangements for working between systems and at a sub ICS scale.

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2. **What happens to CCGs and the role they used to play?**

The shift away from an “internal market” where purchasers buy care from NHS trusts and other providers raises the question of what happens to Clinical Commissioning Groups (CCGs) who currently fill that purchasing role.

The Long Term Plan says CCGs will become streamlined and more strategic. In a scenario where there is one Integrated Care Provider (ICP), one ICS and one CCG for each area as the plan suggests, there is an ambiguity about who has strategic responsibility and holds providers to account. A number of functions currently exercised by commissioners are likely to pass to ICPs in future. Strategic decisions about commissioning may remain with the CCG, or be effectively passed to the ICS.

This may create a different dynamic as ICSs will be partnerships lacking the powers and structures of statutory bodies: their members may include providers themselves.

These proposals make it possible that the leadership of ICSs and CCGs will overlap with that of ICPs, and that gives rise to questions about how conflicts of interest will be managed. Roles and lines of accountability become confused. We could see the same people operating as providers within the ICP, accountable to the ICS on which they also sit and also potentially accountable to the local CCG of which they may be a member if they are a GP.

In some contexts, “mutual accountability” might be realistic, where everyone holds one another to account. But this would not work where relationships are either antagonistic or too close so that they create non-challenging monopolies.

3. **What happens to patient choice?**

The proposals emphasise that the ability of patients to choose a care provider for planned care will be maintained or even strengthened. As well as being a right, the ability of patients to go elsewhere is also potentially important as an incentive to offer easy access and high quality, as long as the money follows them as it does under the current “payment by results” system. This is especially a factor in areas like planned operations, specialist outpatients, and talking therapies.

But one of the risks of the ICP/ICS model is that the integrated providers that will work to them will have incentives to provide services within their organisation when patients might benefit from being referred to providers that are not part of the system.

The ICS could have an important role in making sure this is maintained but that would require independence from providers. This means that there are some decisions which still need to be reserved to commissioners. This may be difficult to enforce if the CCGs are subsumed into the ICS, with the same leaders in charge of both, or if the ICS is dominated by large provider organisations.

4. **What is the model for improvement?**
In 2004 Simon Stevens set out the rationale for the then Labour Government’s extensive process of reform. He argued “the history of NHS reform since 1991 has shown that a unidimensional reform model (be it cooperation, competition, or command and control) will not be sufficient to generate high performance in a sector as complex and varied as health care.”

The “three dimensional reform” strategy described by Stevens encompassed
1. **Support for providers** – including increasing supply of health professionals; modernising infrastructure; supported learning and improvement.
2. **Hierarchical challenge** – including national standards and targets; inspection and regulation; published performance information; earned autonomy for providers (Foundation Trusts).
3. **Localist challenge** – including active purchasing; patient choice; aligned provider incentives; new entrants and plural supply; local democratic accountability through role of members and governors of Foundation Trusts.

The Lansley reforms of 2012, put much greater emphasis on competition (localist challenge) with little investment in provider support. In practice there was also heavy focus on hierarchical challenge.

The proposals in “Implementing the NHS Long Term Plan” appear to narrow the number of factors pushing for reform even further. There is little by way of support for providers except in primary care, with training and capital budgets cut and little central support for learning and development. There will be hierarchical challenge but gone are the incentives around earned autonomy that the Foundation Trust regime sought. The localist and competitive challenge is considerably weakened as the lines are blurred between commissioner and provider, the Foundation Trust model effectively abandoned, and there is a move away from payment based on volume of care.

So what is supposed to encourage and incentivise services to improve in this new system – and will it be enough?

5. **Will this result in a centralisation of national power?**

The English NHS is already highly centralised compared to the health services of many other countries. There seems to be a risk these proposals will intensify that in the long term.

Without careful design and thought the new ICS tier is likely to take over many decisions currently made more locally by trusts and CCGs. Because the ICS is not a statutory constituted body but a partnership very dependent on functional relationships, with some potential to mark its own homework, there will be a temptation for NHS England and its regional teams to call in decisions to an even higher level. The powers to intervene in trusts, set capital expenditure limits and to mandate mergers will sit with the Regions and NHS England.

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2 Reform Strategies for the NHS, Simon Stevens, Health Affairs, Vol 23. No 3 , pp37-44
https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.23.3.37
The proposal on Foundation Trust finances in section 5 is a particularly direct centralisation of power. Foundation Trusts were originally conceived as autonomous organisations able to retain surpluses and invest them where its management and governing body deemed fit. The removal of that financial freedom removes a fundamental principle in how these bodies were supposed to be motivated to balance their books and improve.

More immediately, the proposal risks undermining the 70 or more foundation trusts which were already balancing their books for all or some of the last three years but who generated further surpluses to partially off set the NHS-wide deficit position, in return for cash incentive payments from the Sustainability and Transformation Fund and its successor, the Provider Sustainability Fund.

Those STF/PSF payments to foundation trusts in surplus have totalled around £1.5bn over the last three years and were made in exchange for organisations delivering significantly higher efficiency savings than those required to simply balance their own books. Staff and trust boards were encouraged to push for those ambitious savings based on the promise that the cash incentive payments from the STF/PSF would form the basis of future capital investment. It will be a difficult message to communicate that this may not be possible after all. There is a risk that this will be remembered for some time as a totemic instance of central Whitehall policy explicitly undermining local NHS leadership.

6. Will the public be able to hold services to account?

Within a more cooperative NHS where competition and local oversight are less prevalent, one source of legitimate scrutiny could be a greater role for the public, patients or their representatives.

Options might include an enhanced role for local councils, or the Health and Wellbeing boards which have a duty to encourage the health of the general population and which bring councils together with NHS bodies and local branches of the patient representative body Healthwatch. Crucially, these bodies have independent legitimacy and independent responsibilities, making them potentially better suited to oversight than bodies more closely enmeshed with the ICP of a local area.

Yet the proposals contain no mention of options like this; the immensely complex new system may be harder than ever for patients and councillors to understand and pin down; and the distinctive autonomy of foundation trusts which do have a role for the public as governors, risks being eroded. Is this an area where more needs to be considered?

7. What happens if local areas do not cooperate?

While we welcome the renewed emphasis on the need for collaboration between NHS bodies in integrated care systems, experience suggests that under the pressure of difficult decisions, in some places relationships will be far more strained. How is the new system supposed to deal with these difficult cases?
The proposed lever is a legislatively imposed ‘duty to collaborate’, but this is likely to have limited effectiveness. The contract held by NHS providers already requires them to cooperate in the interests of patients\(^3\) and it is not clear how this additional proposed duty will enhance this in practice. In any case, it is not clear that new rules from the top can drive collaboration. Applying a legislative or regulatory solution will certainly not resolve complex historical issues or other blocking factors such as payment mechanisms or competing duties for boards easily. It may be more effective where individual leaders are blocking change, but care needs to be taken to ensure that application of the lever does not simply mirror the bad behaviours which the wider system is seeking to shift.

The question for national leaders is how they intend to change their approach in order to support systems in collaboration, and how they will respond where collaboration proves to be difficult.

**8. How would we know if this works?**

The legislative proposals are unbundled from the important goals set out in the Long Term Plan, so it is less than entirely clear exactly how each change is supposed to lead to improvements that patients would notice. Are ICSs and ICPs intended to lead to improvements in how joined up care seems to patients? Are the measures on procurement and competition intended to lead to lower overhead spending on administrators? More clarity on this would be welcome. A high level of ambition is not necessarily the best outcome. Sustainability and Transformation plans in many parts of England ultimately came to involve signing up to what turned out to be unrealistic targets to reduce hospital activity\(^4\), setting them up to be seen as unsuccessful.

We assume that an impact and risk assessment will be published before the proposals are introduced to the House of Commons. It will be important that this looks honestly at what have often been the unintended side-effect of NHS legislative change in the past: a degree of disruption and a shift of managerial attention from delivering results to changing the mechanics of the system\(^5\).

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\(^5\) [https://www.nuffieldtrust.org.uk/comment-series/doomed-to-repeat-it](https://www.nuffieldtrust.org.uk/comment-series/doomed-to-repeat-it)

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