Written evidence submitted by the Nuffield Trust (HSC0002)

The Department for Health and Social Care published *Integration and innovation: working together to improve health and social care for all* on February 11th 2021, laying out proposals for wide-ranging legislative change around the English NHS. This short submission to the Committee summarises Nuffield Trust views on the effect such legislation would have, the opportunities and risks, and priorities for further scrutiny and possible amendment ahead of the tabling of a Bill.

In our view, key issues to be considered include:

- We generally support the direction of travel which works with existing NHS aims, and the flexibility in parts of these proposals.
- The hope of joining up health and social care is likely to be undermined by the dire state of the social care sector, which is failing to provide any support at all to many people who need it. Sadly, this White Paper does nothing to meet the Government's explicit promises of meaningful reform.
- The new structures for integrated care systems are complex. They may in practice be dominated by the NHS and by NHS trusts, with a risk of conflicts of interest. It is not clear that these precise structures should be universally mandated.
- Responsibilities for ICSs to control NHS finances may lead to tension. CCGs were unable to do this effectively. Powers over capital spending, backed by new powers to set caps for foundation trusts, remove the incentive to deliver savings to invest.
- Structural reform carries a risk of disruption and distraction: this needs to be closely monitored and timescales should remain flexible given how much the NHS is dealing with currently.
- As previous governments recognised, giving ministers more latitude to reorganise and control services can lead to politicised micromanagement. The new powers for the Secretary of State to reorganise bodies and direct NHS England should be subject to enhanced Parliamentary scrutiny.
- New powers to intervene where individual local authorities are not fulfilling social care obligations are poorly suited to a period where structural underfunding and dysfunctional system are the main cause of failure. These could be moved towards a more helpful role for the CQC in overseeing the market of care provision.
- Expanded powers to intervene in service changes risk leaving the Secretary of State on the political hook for every major shift in services across England, with strong incentives to block change. There is a case to look at limits on the scope of this, and make sure clear independent advice on safety and clinical appropriateness remains.
- Although the existing procurement system can be associated with pointless bureaucracy, the proposed approach may not reduce it and the tests for not going out to tender under the new rules are rather unclear. There is a risk of cosy local monopolies emerging, shutting out innovators and reducing choice for patients.

1. Changes to the local and regional structure of the NHS

1.1. The white paper lays out a new statutory structure for the NHS where Integrated Care Systems (ICSs) take on a general local planning and funding function, operating across populations of over 1 million people. Planning and purchasing for local health needs as currently carried out by Clinical Commissioning Groups, as well as capital planning, will be exercised by an "NHS Body" within the ICS. This will be overseen by a board made up of representatives from trusts, GPs and local authorities, with its own Chief Executive who will be Accounting Officer for money spent by the NHS body. The NHS body will not be able to simply direct NHS trusts.

Meanwhile, a separate Health and Care Partnership within the ICS will develop "a plan to address the health, social care and public health needs of their system". The latter will not make binding decisions on NHS organisations or councils. Its board will be made up of the same membership as the NHS body and others including the voluntary sector, other local services such as housing, and private providers. The NHS body and local councils must have regard to its plan.

This structure will coexist with other local committees with roles connecting the system:

- health and wellbeing boards of local councils, which also represent the NHS and local government and will continue to develop Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies;
- programme boards;
- management of the provider collaboratives anticipated in the White Paper.

Overall we find much to welcome in the broad thrust of this. Unlike many earlier NHS structural reforms, they work with the grain of what the service is already doing at a local level. There is considerable potential for improvement in different parts of the system working together better, and this is the right priority to signal to the NHS, social care, and the public.

1.2. The structure is designed to catalyse local systems to work together, and to address concerns from local government of an NHS takeover. However, a number of possible issues should be closely considered.

The sheer burden of meetings on local managers, clinicians and officials will be increased. The general lack of binding powers is intended to facilitate a more consensual system, but could lead to gridlock, especially if relationships are bad.

The role of the NHS as a potentially dominant component may cause frictions. ICSs will be units of financial control and performance management, requiring a set of conversations which may be alienating to non-NHS participants. There is the risk that an "NHS core" centred on the NHS body will remain quite separate to the wider system.

NHS trusts are the largest and best-funded health and care organisations in each area, and there is a risk that they will become dominant over the NHS body. As the NHS body takes on the responsibilities of

CCGs for selecting providers and giving out money, along with additional responsibilities for trust capital spending, there is a real risk of conflicts of interest. The White Paper does not contain details of precisely who will be on the boards, how they will operate, or how they will handle such conflicts.

The White Paper tries in several places to protect flexibility, setting out plans to permit other forms of joint working as well. The Committee and MPs may wish to consider whether this principle should be extended to allow different ICS structures, whether generally or by particular permission.

1.3. It is welcome that the White Paper does not try to spell out detailed operational answers to how integration should proceed, and that it recognises these will need to be worked out locally. What may not be fully appreciated centrally is that this takes a systematic learning process and above all time. The White Paper assumes reforms may begin in 2022: an important decision for the Committee to consider will be how mandatory and how flexible this timescale is in view of the very serious operational challenges the NHS is likely to see for the foreseeable future during and after Covid-19.

1.4. Our work on the history of previous NHS structural reforms, notably the 2012 Health and Social Care Act, has shown policymakers easily underestimate the costs of change in the form of:

- Direct costs in consultancy, IT changes, and redundancy payouts.
- Distraction from operational issues into internal processes.
- Losing organisational memory, skills and relationships through redundancy and turnover in personnel.
- Overestimating savings through removing "bureaucracy" inherent in the old system, by not recognising the administrative requirements of the new one.

The new White Paper explicitly recognises this risk, a serious improvement. Some of the risk of change is reduced this time as ICS already exist in shadow form, and NHS England is proposing to guarantee job continuity to CCG staff. But there will be a need for new chief officers in some places, changes in roles, and new structures and functions that could quite easily trigger a round of appointments, restructuring and redundancies nonetheless. This, and disruption to relationships will be even worse if some ICS boundaries need to be redrawn to create coterminosity with upper-tier authorities. It is inevitable that these changes will mean at least some managerial time being occupied by reorganising structures, rather than improving services.

In view of the shortcomings highlighted by the NAO in estimates of cost in 2012, there should be clarity and scrutiny about these in 2021. Monitoring of disruption and distraction will be necessary and should be acted upon.

1.5. The White Paper states that "There will be a duty placed on the ICS NHS Body to meet the system financial objectives which require financial balance to be delivered. NHS providers within the ICS will retain their current organisational financial statutory duties."

Earlier reforms have struggled with financial flows that did not match the accountabilities and incentives policymakers wanted, and a number of possible tensions will exist this time. The governance of ICSs by boards including trusts, and their lack of direct powers, may make them weak as units of direct financial performance management. CCGs proved earlier unable to influence trust expenditure in the way that the DHSC needed, resulting in the system of control totals imposed directly on trusts.

If they are required to exert financial discipline at an ICS level, this may lead to tension between the NHS body and trusts, and between one trust and another over perceptions of who is and is not pulling their weight in delivering savings. This could disrupt the integrating relationship hoped for and the somewhat uncertain role of primary care in these new structures may exacerbate this.

Currently a sophisticated national allocation formula distributes NHS funds at the level of GP practices aggregated into CCGs, taking into account many traits of local population and unmet need. The White Paper seems to anticipate ICSs, which will be four or five times larger than CCGs on average, replacing them as the units of allocation. It states "ICSs will also want to think about how they can align their allocation functions with place" – suggesting that they may be responsible for distributing funds to smaller "place" areas within their patch. There are risks here around losing sensitivity to local needs by aggregating up to larger areas, and allowing ICSs to redistribute funds based on less extensive consideration than the formula offers - especially if they are incentivised to do so to plug deficits and deliver their financial role. The neediest areas of England may be the losers.

It remains somewhat unclear whether the Chief Executive of an ICS NHS Body is in fact intended to be an "Accounting Officer" in the general public sector sense. If so, this would mean that they are directly responsible to parliament, as would be the NHS Foundation Trust Chief Executives on their boards against a separate set of responsibilities.

These complexities and uncertainties sit awkwardly with the National Audit Office principles on accountability for taxpayers' money, which emphasise "Clear roles and someone to hold to account".

1.6. Since the establishment of Foundation Trusts, their ability to build up surpluses to spend on capital projects has been, as intended, a strong incentive to become more efficient. The White Paper would weaken this dynamic. It pledges to introduce "a new capital regime where integrated care systems (ICS) are allocated a system-wide capital limit, and have duties placed upon them to create a capital plan". This would be backed by a "targeted reserve power" to set a capital spending limit on Foundation Trusts, removing their legal autonomy to disregard such limitations.

Even if this power is relatively seldom used and plans are mostly consensual, Foundation Trusts will now know there is no certainty that they will be able to reinvest surpluses as they choose. What is replacing this to ensure that organizations accounting for a very large proportion of total health spending, and retaining considerable autonomy, feel it is in their interests to make savings?

2. Changes to the powers of the Secretary of State

2.1. The White Paper proposes extensive new powers for the Secretary of State, notably:

- To transfer powers to and from different arms-length bodies (such as NHS England), and to abolish those bodies by Statutory Instrument.
- To abolish and merge professional regulators.
- "Allowing the Secretary of State to intervene at any point of the reconfiguration process" where changes are proposed to local services, without this needing to be referred to him or her by any local body or process.
- "To formally direct NHS England in relation to relevant functions."

2.2. The machinery for oversight and transparency in the exercise of national powers will need to be strong, and MPs should consider their ability to exercise scrutiny. Politicians face electoral incentives which are not aligned to the optimal running of a health service, as was recognised in the 2010 White Paper which created NHS England to "help prevent political micromanagement". It is well known that Secretaries of State for Health from both parties have in the past revised the allocation formula for NHS funds in a political context and there is no reason to think this is a thing of the past. The Public Accounts Committee last year warned that ministerial selection of towns to receive growth funding was "not impartial".

The document suggests that powers over arms-length bodies would "only be exercisable via a Statutory Instrument (SI), following formal consultation". These powers would enable a future government to carry out reorganisation on a scale usually done in the NHS through primary legislation. At the least, these statutory instruments should go through the affirmative procedure with inspection by a committee of MPs.

The White Paper implies that there will be limits and transparency requirements associated with intervention by the Secretary of State in NHS England, but provides no details. In the interests of accountability and the ability of MPs to provide scrutiny, directions to NHS England should be openly published, and there is a strong case that they should also be made by Statutory Instrument requiring the consent of Parliament.

2.3. Expanded powers of intervention in reconfiguration may create difficult political incentives for the Secretary of State and for MPs that do not align with the best interests of people's health. In effect the Secretary of State will be personally politically responsible for changes to local services, constantly having to choose short term political pain or vetoing changes regardless of their clinical merit. This has under previous systems led to actions few would defend, including Lord Lansley's halting of work on stroke reconfiguration in London which, when it ultimately proceeded, appears to have significantly reduced deaths.

The White Paper leaves undefined exactly what will succeed the current Independent Reconfiguration Panel. Rational decisions are likely to be incentivised if there is a strong body which can credibly assess proposals for change based on issues of safety, standards, patients access and other planning criteria

and the IRP has discharged this role well. It may also be worth MPs considering at least some appropriate criteria being applied to which cases are effectively placed before the Secretary of State.

3. Social care

3.1. The White Paper proposes a set of changes to social care law:

- New duties for the CQC to assess how well local authorities are delivering social care responsibilities, and for the Secretary of State to intervene where they fail.
- New powers to collect social care data.
- A new power for the Secretary of State to make direct payments to providers.
- "Discharge to assess" provisions where individuals' care needs can be assessed after leaving hospital.
- A standalone power for the Better Care Fund.

As the document itself acknowledges, these do not constitute a viable reform to a collapsing system. The passage of the Bill will likely take us to almost two years since the Prime Minister said "I am announcing now – on the steps of Downing Street – that we will fix the crisis in social care once and for all with a clear plan we have prepared to give every older person the dignity and security they deserve."

This situation is unacceptable. A large amount of policy work on options for reform has been done by a succession of civil service teams for decades. Before Covid-19 our analysis showed 163,000 people over the age of 65 had high care needs but were receiving nothing: many younger individuals are also being failed. Workforce vacancies are widespread, and thousands of people each year are affected by providers closing or refusing to renew contracts with councils because of the very low rates paid. This degree of failure would be unthinkable in health or education. The pandemic itself appears to have pushed the sector into even greater financial difficulties. The Prime Minister's focus on older people, while welcome, failed to address the problem of social care for working age adults which is in an even more difficult state.

In this context, it will be very difficult to deliver the joined up services hoped for. From the point of view of many people in need of social care, there is nothing to join up.

3.2. The role local government will play on ICS NHS Bodies and the Partnership Board is not entirely clear. Will local government be an equal partner, or will an ICS be an NHS organisation with local government representation on it?

The answer to this will most likely vary by area but if the former is the aspiration, there is a serious question about its realism given the different starting points of the NHS as against social care (and indeed public health). Given the different accountabilities of local authorities to their electorates and the NHS to the DHSC, which would be enhanced and changed by this White Paper, this question is likely to be tested on some quite difficult issues.

One key question is to what extent funding will flow between the NHS and social care where we still have one system that is free at the point of use and one that is means-tested, with many people paying out of pocket. Blending the workforce across the sectors will also be difficult, because there is a sharp disparity in pay and conditions

3.3. Covid-19 has highlighted the absence of any robust national data on who uses social care services (particularly on those who self-fund), and we welcome the proposals to improve this. Any attempts to introduce mandatory data submissions for the sector must make sure what is collected is high quality and is useful to government, providers and councils; and that providers, many of whom are small organisations, have the funding and support to respond properly and without disruption.

3.4. Direct payments to providers also addresses a particular issue that emerged during Covid-19. Under these proposals, the DHSC would have powers to allocated funding directly to providers, something that can currently only be done for the minority who are non-profit organisations.

This new mechanism should not be used in place of a more sustainable funding solution for the sector. It should be deployed in consultation with local authorities, and must avoid favouring care homes over other types of provider, a perception that arose with support during the pandemic. Using it outside an emergency, particularly to favour certain firms, might infringe the state aid provisions of the Trade and Cooperation Agreement with the EU.

Our understanding is that proposals around the discharge to assess and better care fund elements are not likely to have a significant impact on day to day operations.

3.5. More significant are the proposals around local authority assurance. Covid-19 has clearly shown that oversight of the sector is weak and that the DHSC holds few levers over the system. Our forthcoming publication on the care provider market will make clear that local authorities are not consistently fulfilling their duties as set out in the Care Act.

However, this is largely for structural reasons rather than for reasons amenable to enforcement against individual councils. Local authority funding from central government is half what it was a decade ago. While there will be instances of under-performance, many are struggling to fulfil their duties because of a lack of resources.

The assurance proposals would see a new duty for the CQC to assess local authorities' delivery of duties. This move, which should learn from how the former Audit Commission oversaw local authority performance before it was disbanded, would require increased capacity.

It misses an opportunity to bolster the CQC's role in regulating the provider market – at present, the CQC only has capacity to monitor the financial health of a fraction of the provider market and its powers are largely reactive. Shifting the focus of the CQC's role to a more proactive one centred on improvement on both the provider and commissioner side would offer greater opportunities to drive quality of care.

4. Changes to procurement and competition

4.1. Alongside the White Paper, NHS England published a proposed provider selection regime. This would replace existing procurement rules, removed under the White Paper, in governing how ICSs choose which organisations to fund in providing care.

Our initial judgement is that the new regime appears to consider a range of relevant issues, and there is a case for change. It is debatable whether the level and type of procurement activity under the current rules is in fact legally necessary, but it cannot be disputed that many local NHS officials think they have to undertake activities they do not see as valuable.

4.2. It will not necessarily be the case that a different regime means less workload. Any form of procurement, if done well, requires a rigorous approach to ensure quality and value for money.

4.3. There is a danger of an overly cosy approach that favors incumbents and excludes innovators. Commissioners are to use a test of whether an existing provider is doing a "sufficiently good job" as a test of whether to open a contract out to others: while criteria are given this seems vague and far from transparent. Similarly, "elective services which rely on cross-specialty working" meet a threshold for renewal: this could cover a very broad range of services.

It is worth giving thought to formal and particular monitoring of proportion of contracts which change from year to year, and of indicators of patient choice though this has always been challenging to measure.

The proposals would retain the "Any Qualified Provider" model for elective care, where commissioners fund any organisation meeting standards which provides elective care at a rate per patient who chooses that provider, and the legal right of choice for a first appointment. This should help to retain patient choice. However, these would continue not to apply to non-consultant-led services, and whether patients get a choice here is a choice for commissioners.

4.4. The proposals would also remove the jurisdiction of the Competition and Markets Authority over mergers involving Foundation Trusts. NHS England would instead be responsible. Again, it would be an error to see this necessarily as removing the need to take the effect on competition into consideration. Title 11 of the Trade and Cooperation Agreement with the EU signed last year requires the UK to control mergers "which may have significant anticompetitive effects". Health is not exempted as a sector. While exemptions are possible "in pursuit of legitimate public policy objectives", the White Paper is not clear as to whether the Bill will seek to establish such an exemption explicitly and MPs may wish to scrutinise this issue.

5. Public health

5.1 In addition to general powers to move responsibilities between arms-length bodies, the White Paper also suggests a new power to delegate public health responsibilities from the DHSC to NHS England outside the existing framework of annual agreements.

5.2. The lack of clarity about the purpose of these new powers makes it difficult to appraise them. Moving public health responsibilities to NHS England is an important decision. There are advantages and disadvantages to health improvement responsibilities sitting with local authorities who control many of the determinants of health, or with the NHS who runs the front line of health care. If NHS England felt it could not agree to take on certain powers, there is a case for examining the decision to compel them and a requirement for statutory instruments at least may be advisable.

It is important to recall the wider picture of growing disinvestment in public health over the past decade: the opposite to what is implied by rhetoric about spending more money on prevention. If health improvement services are not meeting our aspirations where they currently sit within the public sector, there must be a serious question about whether this is really because they sit in the wrong place, or simply because we have moved large sums of funding away from them.

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