

Redrawing the health and social care architecture

Exploring the role of national
bodies in enabling and
supporting the delivery of
local health and care services

November 2016



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Foreword

The NHS is rightly a source of national pride in the UK. But the service today is under significant financial and demand pressures. These pressures only look set to increase and the demands on the service and on social care services provided by local councils mean we need a radical shift in the way health and care services are delivered.

This challenge has been embraced by local providers and commissioners up and down the country in line with the vision presented by the Five Year Forward View (the 'Forward View'). However, to date there has been a missing piece to the jigsaw: what is the role of national structures in enabling the delivery of localised and integrated care, and how can this role be optimised?

It is this question that we have sought to explore in this report. We've held extensive dialogue with senior leaders at national, regional and local levels across the service to canvass their views. We've consulted over 1,000 people working across the health service, from the Department of Health, NHS England and NHS Improvement through to the front line. And we've conducted a polling exercise involving over 2,000 members of the public.

What we found is a widespread feeling that the current national structure is ill-designed for the vision which the service has set itself. A persistent underlying sense of confusion about the roles of national bodies, and a

frustration over the separation of roles and functions in the national health and care system. It's evident from our findings that there is a growing appetite for reform, not least so that local systems can be enabled to deliver on the Forward View's vision.

With this in mind, we have focused on setting out a bold and radical way in which policy makers could seek to move forward, in the explicit hope of provoking debate and elevating this issue for further consideration. Clearly a structural change can only be an enabler to a much broader set of changes and innovations that the sector needs – but moving on from today's imperfect approach is necessary.

I'd like to thank personally all of those who took part in the research, whether through being a member of our Steering Group, attending our roundtables, or taking part in an interview.



David Morris
Partner, Healthcare

We want to hear from you

We hope you find this report useful. We would very much like to hear your thoughts if you have views and experiences to contribute to this issue.

Please get in touch with the authors or email us at: newhealth@uk.pwc.com



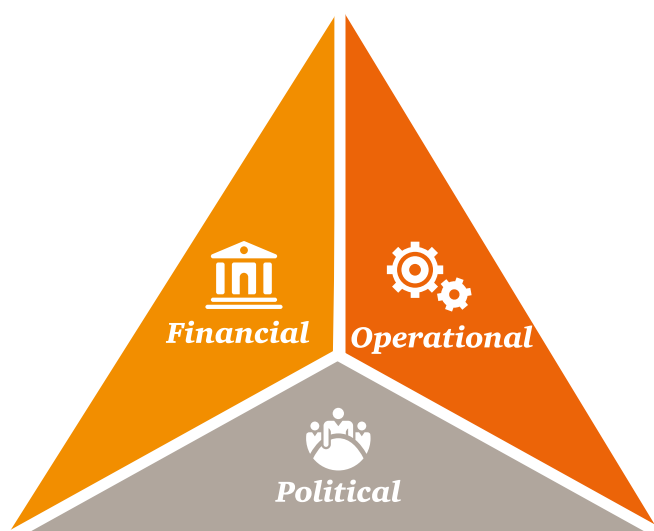
Executive summary

The context

Since its inception, our country's care system has had both national and local dimensions. The National Health Service was created to be a national institution offering a universal service to all UK citizens. That is one of the reasons it is such a source of pride at home and admiration abroad. Yet it is fundamentally a service that is delivered locally, adapting to the particular needs of patients in the local communities it serves. In the case of social care, this local dimension is extended further as – unlike the NHS – it is democratically accountable to local people through local councillors and part financed through local taxation.

There is, and has always been, a tension between this national-local duality. As a result, there has been no consistent answer to the question of where public accountability, financial responsibility and operational control ('the accountability triangle') should best lie in order to deliver the services people need at a cost acceptable to the taxpayer. Although the recent trajectory, from the internal market reforms of the 1980s through to the creation of primary care and NHS foundation trusts in the 2000s, has been towards local leadership, there have nonetheless been periodic swings back towards more centralised control.

The accountability triangle



The reforms resulting from the 2012 Health and Social Care Act attempted to fundamentally reshape this accountability triangle by delegating responsibility for operational, financial and strategic decisions to local clinical leaders (in Clinical Commissioning Groups) and by replacing central planning with market-based

mechanisms. With time and a fair wind this approach may have worked. But many view it as an imperfect plan from which policymakers were forced to beat a hasty retreat. In the process of doing so, a range of measures were introduced to blunt the reforms and reintroduce elements of central control. These were tactical changes, not strategic, with no overarching organisational blueprint. In addition, there was resistance to enacting further legislation to formalise the changes in statute.

What has emerged is a complex middle-ground between central control, devolved decision making and a market-based approach. In our view this is misaligned to today's challenges, adds complexity and duplication, and frequently hinders the progress local leaders are seeking to make. Yet there is cause for optimism. The Forward View has created a new consensus behind integration and collaboration across health and care, which, it is argued, can deliver better outcomes at lower cost.

To support the delivery of the Forward View, local commissioners and providers are being asked to put institutional interests to one side and come together in local care systems. This move towards integration at a local level is not, however, reflected in the interventions that the front line experiences from national organisations. Each national body holds local leaders accountable for the delivery of a range of standards and outcomes.

As a result, a single provider finds itself answerable to, or impacted by, a myriad of national organisations and faces the daunting challenge of managing competing requirements. The Care Quality Commission (CQC) instructs NHS providers to invest in service quality, for example; NHS Improvement (NHSI) demands improvements primarily in financial performance; while NHS England (NHSE) expects a shift from acute to community provision. At the same time, the shift towards integrated and person-centric care means the longstanding division between health and social care looks increasingly anachronistic.

The delivery of health and care is personal and local. Does the new national infrastructure support this long term? The jury is out and we'll have to see. NHSE and NHSI are working hard to show that they are sensitive to variation and to local needs and both will be essential if these national bodies are to improve people's experience of care.

Dame Una O'Brien
Former Permanent Secretary,
Department of Health

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To the great credit of those in charge, the health and care system's national leadership is increasingly operating collegiately and collaboratively. NHSE, NHSI and the CQC are working hard to align and adjust their regimes to reflect the need for a systems-based approach, as seen in recent planning guidance. But, in truth, these leaders are having to coerce the national architecture to manufacture a solution for which the system was not designed. Despite their best efforts there is too much uncertainty and too little clarity. And too much of what national leaders have to do relies on informal exhortation and collective agreement, rather than formal jurisdiction. This creates space for behaviours at national and local levels that run counter to the spirit of more integrated and devolved systems of care.

Our work

To date, little attention has been given to how these architectural ambiguities should be addressed. Critically, no-one has satisfactorily answered the question of whether the balance of public accountability, financial responsibility and operational control needs to be revised to enable local systems to deliver successful and sustainable services for the communities they serve. In recognition of this gap in thinking, we commissioned research to explore what the public and staff working within the NHS thought of the national architecture and to start the debate on what changes are to better support local systems in delivering sustainable services in their areas. While this report focuses on England, our findings may also have valuable lessons for the other parts of the UK and further afield.



Our findings

Through our work we identified five areas for improvement in the current arrangements. Together they constrain the progress of local systems in developing the place-based, integrated health and care systems envisaged by the Forward View. They are:

1. a misalignment between national bodies' remits and the objectives of local systems;
2. duplication and complication of tasks across multiple organisations, especially in the roles of the Department of Health (DH), NHSE and NHSI;
3. an imbalance between political accountability, financial responsibility and operational control;
4. a missing link between local systems and national bodies; and
5. the lack of a single organisation with responsibility for securing and developing the critical resources required over the long term.

The need for change came through clearly in our polling of the public and of NHS staff for this report. It suggested that there is:

- **widespread confusion over the role of national bodies among NHS staff:** a large majority of senior staff in the NHS are not clear on the role of NHSE (70%) or the DH (70%), while only a minority understand the role of NHSI (16%);
- **deep frustration with the separation of roles and functions in the health and care system:** two in three NHS employees (66%) identified the division between health and social care as a barrier to delivering the vision of local integrated care systems outlined in the Forward View;
- **little clarity about the role of local organisations in improving services:** over a fifth of the public hold the Westminster government responsible for the quality of care in their local hospital or surgery (22%);
- **a growing appetite for reform:** 71% of NHS staff felt there was a need for change to the current system and only 11% felt that current arrangements were effective.

There is such opportunity within the health service to do better...and there's masses for them to learn from local government.

Duncan Selbie
Chief Executive, Public Health England



Many of the findings of this polling were echoed in the responses we had from a series of 11 in-depth interviews and six roundtable events that we conducted with key decision-makers in the health and care system.



We are all in this together. There are very few regulators who'd actually go and do a better job of running services than the people who are actually running the services.

Stakeholder interview



Our recommendations

Our recommendations are set out in two stages. The first – 'simplification' – describes how short-term evolutionary changes could clarify the roles and responsibilities of national bodies and better align them to the needs of local systems. This will enable better working in the delegation of power from national to local bodies. The second stage – 'reform' – builds on the simplification stage to enable a truly sustainable, fully devolved and integrated health and care service. It would do so principally by enabling politically accountable local bodies to take on additional powers and responsibilities, thus enabling full devolution of power from national to local bodies. We suggest this two-stage phased approach because:

- immediate organisational upheaval presents a risk to a system struggling with profound performance and financial issues;
- the current national architecture is slowly evolving (take the suggestion in the 2017/18 Planning Guidance that Sustainability and Transformation Planning footprints may not be temporary, for example); and
- the transition to local integrated care systems exercising devolved powers will take time and will necessitate a very different national architecture to the one we have now.

So, while it may take the best part of a decade to arrive at our proposed end point, setting a firm direction of travel now means policymakers can provide a clear roadmap of change. That in itself will help bring greater certainty to the care system.

Short-term simplification

The priority for the short term must be to simplify the existing architecture to reduce confusion, clarify roles and better enable the emergence of the new models of care outlined in the Forward View. The three proposals that make up our simplification model are consistent with the current direction of travel and, if fully implemented, could result in an efficiency saving of up to £0.5' billion annually.

Proposal 1. Clarifying and co-ordinating the work of national bodies

The ad-hoc attempts to better co-ordinate key national bodies should be formalised. One option might be to create a 'Care Management Board' consisting of the chief executives of NHSE, NHSI, Public Health England (PHE) and Health Education England (HEE), together with representatives from social care. Such a Board would co-ordinate the policy and activity of its constituent organisations in supporting, challenging and directing local systems.

[The] national bodies have a collective view... they're the only people who know what's happening in all parts of England.

Stakeholder interview



Co-ordination could then be taken further through targeted reorganisations. HEE could, for example, be subsumed into NHSI to ensure that providers' requirements are fully informing workforce considerations.

A more comprehensive reorganisation, in which NHSI, NHSE, HEE and the wellness and prevention functions of PHE are merged into a single 'National Care Authority' (NCA), could also be considered. This body would represent a single point of accountability and authority in the system and could result in substantial savings, although the risks in creating such a large non-departmental body would need to be carefully assessed.

Proposal 2. Clarifying and co-ordinating the work of local institutions

The move towards integration at a local level is universally welcome. But our research revealed a consistent message about a missing piece of the current architectural jigsaw: a bridge between local systems and national bodies. There is no permanent function that currently performs the role of co-ordinating local institutions or translating national requirements into local actions.

Recent planning guidance suggests the temporary Sustainability and Transformation Planning footprints (STPs) could perform a useful role beyond their current remit and we suggest that NHSE build on that insight and delegate responsibility for improving standards and managing resources across health and social care to new, permanent Regional Care Groups (RCGs). To support these RCGs, NHSE should, over time:

- delegate to each RCG the financial resources allocated to organisations within its jurisdiction;
- transfer responsibility for commissioning primary care and specialist services to RCGs; and
- provide RCGs with mechanisms to intervene in local commissioning to create a more integrated service for patients.

In some parts of the country RCGs are likely to emerge from the existing STPs. In others, where STPs are poorly aligned to patient flows, do not align with community boundaries, or are not delivering tangible benefits, new geographical configurations will need to emerge.

I think I would support the route that NHS England is taking with STPs and the creation of some new models of care as examples because the best route to creating more changes is to establish some robust reproducible examples.

Sir John Oldham
National Clinical Lead for Quality and Productivity, Department of Health



¹ We estimate that the aggregation of commissioning activities by RCGs could save at least 1/3rd of the current £1.1bn administration spend of CCGs nationally (£367m) and ¼ of the £443m combined annual running costs of NHSE and NHSI (£110m) Sources: NHS England Annual Report 2015/16, Monitor annual report and accounts 2015/16, NHS Trust Development Authority annual report and accounts 2015/16.

Proposal 3. Clarifying and co-ordinating the role of Whitehall departments

The DH has been stripped of many of its functions over successive decades, as first the NHS Executive and now NHSE and its national cousins have assumed them. As a result, the DH's role is poorly understood by many people in the health and care system. This is amplified by the fact that social care services are funded by the Department for Communities and Local Government (DCLG), not the DH.

The government should make it clear that the primary responsibility of the DH should be the improvement of the health of the population through the strategic oversight of the care system. That core function does not mean running or managing the system. Rather, it means ensuring co-ordination between the constituent parts of the national architecture. And to ensure better co-ordination between the DH and DCLG themselves, we suggest they have a shared objective to act together to facilitate evolution towards a single care system in England. Thus, they should together:

- set a common strategic direction for the health and social care system;
- secure the resources required by the system to deliver its objectives;
- determine common objectives, standards and targets that local systems must achieve for the NHS and social care funding they receive from national and local sources;
- ensure organisations within the system acting on the departments' behalf have the powers and levers to undertake their roles, and are held accountable for using them; and
- explore the potential synergies between the social care element of the Local Government and Social Care Ombudsman's role and the regulatory functions of the DH, NHSI and NHSE.

Outside of these three proposed changes, the current system (including the roles of other national bodies like CQC, NICE and MHRA, NHS Digital, NIB and NQB) would remain unchanged. Equally, to ensure a focus on both the delivery of business as usual and progress towards the Forward View, we recommend the statutory roles and functions of local organisations should remain as they are today. They will continue to operate under a delegated system in which the balance of accountability, control and financing remains with national rather than local bodies.

All the delivery issues, the how, the maximisation of the benefits of different workforce configurations and so on, that's all got to be local.

Professor David Haslam
Chair, National Institute for Health and Care Excellence



I think the perfect balance is to have national rights of access, but to have local power about how the system is, how it develops.

Rt. Hon. Norman Lamb



Longer-term reform

Beyond the short-term changes we recommend, we believe there is an opportunity to unequivocally change the balance of power in the care system over the next decade and resolve current ambiguities through more meaningful devolution of accountability, control and financing to local areas. In time, it should also be possible to overcome the artificial division between health and social care and create a truly integrated care service.

Moving from today's segregated and delegated system to an integrated and devolved framework will require changes at both local and national levels. That will take time and careful implementation. But we believe it is the logical next step after three decades of evolution away from national command and control. Again, we make three proposals to bring this vision about:

Proposal 1. Shifting accountability to the local level

Over time, RCGs should evolve into democratically accountable local bodies and assume responsibility for the integrated commissioning of health and social care. We believe this is necessary to break the accountability stranglehold exercised by Whitehall over local care systems. Such a change will also close the democratic deficit that often makes it difficult for local healthcare leaders to drive change in local services.

Delivering this change is a lengthy, complex and potentially costly process. And devolving authority for a single care system will require flexibility. Different parts of the country should be able to evolve local accountability in different ways: an elected mayor in one area, local government in another, or even the creation of new health and care commissioners elsewhere. We believe RCGs and relevant local authorities should be free to propose to national government the form that local accountability should take in their areas.

Some parts of the country may not wish to move in this democratic direction, of course. In such cases, local systems should be free to explore whether to transfer social care and public health functions to RCGs, or whether a joint commissioning function should be established to serve both health and social care functions. Whichever model is adopted, it seems clear that the existing commissioning infrastructure – notably CCGs and CSUs – will disappear.

Proposal 2. Shifting responsibility for financing local care systems to the local level

In the care system, control of the purse strings bestows power. In social care that power currently resides at both national and

² While our recommendations here focus on council tax (41% of local government revenue), we are also supporting a major programme of research into local government finance led by the IFS which will consider the implications of business rate retention and further fiscal devolution.

local levels, meaning local councils have a strong locus of control even though standards and inspection systems are determined nationally. The funding of local health services, in contrast, is determined at a national level. The transition from a delegated to a devolved model cannot take place unless this changes.

We suggest that where local systems wish to exceed the standards against which national resources have been allocated, local democratically accountable leaders should be given powers to raise additional funds through the existing system of local taxation. In the short term this is likely to mean an extension of the social care precept. But over time it could result in a restructuring of council tax to draw together all additional local

[The] power that I think is critical to devolve... is the power to raise money... you only get real accountability if at least some of the money is raised at the same level that you're spending it.

Stakeholder interview



resources dedicated to health and social care into a single transparent levy for the local population.²

Proposal 3. Shifting control to the local level

The devolution model represents a huge shift in responsibility from the national to the local level, in terms of both political accountability and financial responsibility. If the approach is to be successful, local systems will need time to build capabilities and structures. Each local system is likely to move at different speeds and should be free to take on the responsibilities of the devolution model when they can demonstrate they have the necessary capacity, skills and processes in place. NHSE, working with other national bodies, has a key role in enabling the development of high-calibre RCG organisations from day one.

But once devolution is established, significant reforms to the existing national bodies may be necessary. When responsibility and accountability are devolved to local systems, the responsibilities of national bodies should be far more limited than they are today. This will present an opportunity to rationalise the number and size of national bodies, streamline their effectiveness and commit a greater share of resources closer to the front line.

It is likely that the CQC will continue as a separate organisation to provide independent inspection and regulation functions. Similarly, NICE would also continue as the independent setter of national standards. But NHSE and NHSI would be slimmed down and merged. Their successor body could remain at arms-length or could be absorbed into a new Department of Health and Care.

Conclusion

Our country's care system has evolved over time. Where once it had many of the characteristics of an old-style monolithic nationalised industry, successive governments from the 1980s onwards have fostered greater diversity. Functions that were once the preserve of the DH have been delegated to NHSE, NHSI, NICE and the CQC. Powers that were once exercised nationally have been delegated to local commissioners and providers. More recently, local authorities have joined the journey through embryonic local integrated care systems.

These are welcome developments. Now the opportunity exists to take the health and care system to the next stage of its journey.

The new system we envisage will be a national service, in that its standards and the majority of its funding will be determined, as they are now, at the centre. But increasingly the balance of power will move towards local areas as they assume greater responsibility for the accountability, financing and control of services. Establishing this new system will require carefully phased changes to the architecture of the system.

We are not so naïve to think that a structural change can be a 'silver bullet' solution to the challenges facing the health and social care system. Indeed, there is much to be done at a local and national level to develop more personal, integrated and digitally enabled services and more empowered service users. However, the architecture we propose is one that should allow local systems the space in which to pursue these and develop an approach that is right for their populations.



Scope and approach

Introduction

The NHS is a source of great national pride in the UK, but it needs to continue to evolve to meet the complex and ever-changing health and care needs of the local communities it serves.

While a broad consensus is developing that the direction of travel towards more devolved, place-based health and care systems can deliver better outcomes for less, most of the focus to date has been on how to make such systems work at a local level. Little attention has been given to the role of national health bodies in enabling and supporting the delivery of local health and care services. And few people have considered whether the balance in the public accountability, financial responsibility and operational control triangle needs to be revised in order for local systems to deliver.

In recognition of this gap in the debate, we commissioned internal research to explore what people thought of the national architecture of the health and care system and to examine whether changes were required to better support local systems in delivering sustainable services in their areas. By undertaking this work, we aim to provoke discussion and elevate this issue for further consideration.

We begin with an analysis of the current system, reviewing the existing architecture, and conclude by making recommendations for change in both the short and medium terms. Our proposals are framed by the complex financial and performance challenges currently facing the care system, together with recognition of the reluctance for further reorganisation among a leadership which is already working more collaboratively in the face of these pressures.

Key question

The key question we set out to answer in the course of our research is this:

With the shift towards devolved and more localised health and care systems, what is the role of national health bodies in enabling and supporting the delivery of local health services over the next ten years?



Limitations of scope

The focus of our work has been on the national bodies and functions that oversee the workings of the health and care system, rather than the structures that operate below that. As such, we have accepted the following trends as given:

- the move towards the models of care identified in the Forward View;
- closer working between the health and social care sectors at a local level; and
- the continuation of the decentralisation agenda and the increasing variation of political accountability through devolution.

Throughout our work we have tried to take an agnostic view of the specific models of care, organisational structures and governance arrangements that might take hold at the local level. Indeed, we would expect the national system must be able to deal with a greater degree of diversity in this regard. While this report focuses on England, our findings may also have valuable lessons for the other parts of the UK and further afield.

Approach

We conducted our research over a six-month period and drew from a wide range of sources, including:

- a desktop review of existing literature covering evidence from comparable international systems, academia and think-tanks, and relevant comparisons with other industries;
- four roundtable discussion groups with leaders in health and care organisations in Leeds, London, Birmingham and Bristol;
- two roundtable events with representation from leaders in national organisations;
- one-to-one interviews with key influencers, thinkers, and decision makers³; and
- public and staff polling.⁴

Our work has been overseen by a Steering Group which has offered views on the issues considered, suggested avenues of investigation, and challenged the analyses and conclusions developed throughout the course of the research.

Membership of the Steering Group comprises:

- Rt Hon Alan Milburn (Chair)
- Richard Douglas, former Director General, Department of Health
- Prof Dame Carol Black, Advisor to the Department of Health
- Lord Kerslake, Chair, Kings College Hospital NHS Foundation Trust
- Robin Osborn, International Director, Commonwealth Fund
- Mike Farrar, Chair, Public Sector Health Board, PwC
- Dame Gill Morgan, Chair, NHS Providers
- Sir Andrew Morris, CEO, Frimley Health NHS Foundation Trust

We would particularly like to thank all the members of the Steering Group for their time, energy and advice throughout this process, and remind readers that the conclusions reached and views expressed in this report are those of the authors only.

³ 11 one-to-one interviews were conducted.

⁴ Public polling, 2,190 adults living in England, carried out by Opinium 5-8 April 2016. NHS polling, 1,230 NHS staff in England, carried out by Dods Research, May 2016.

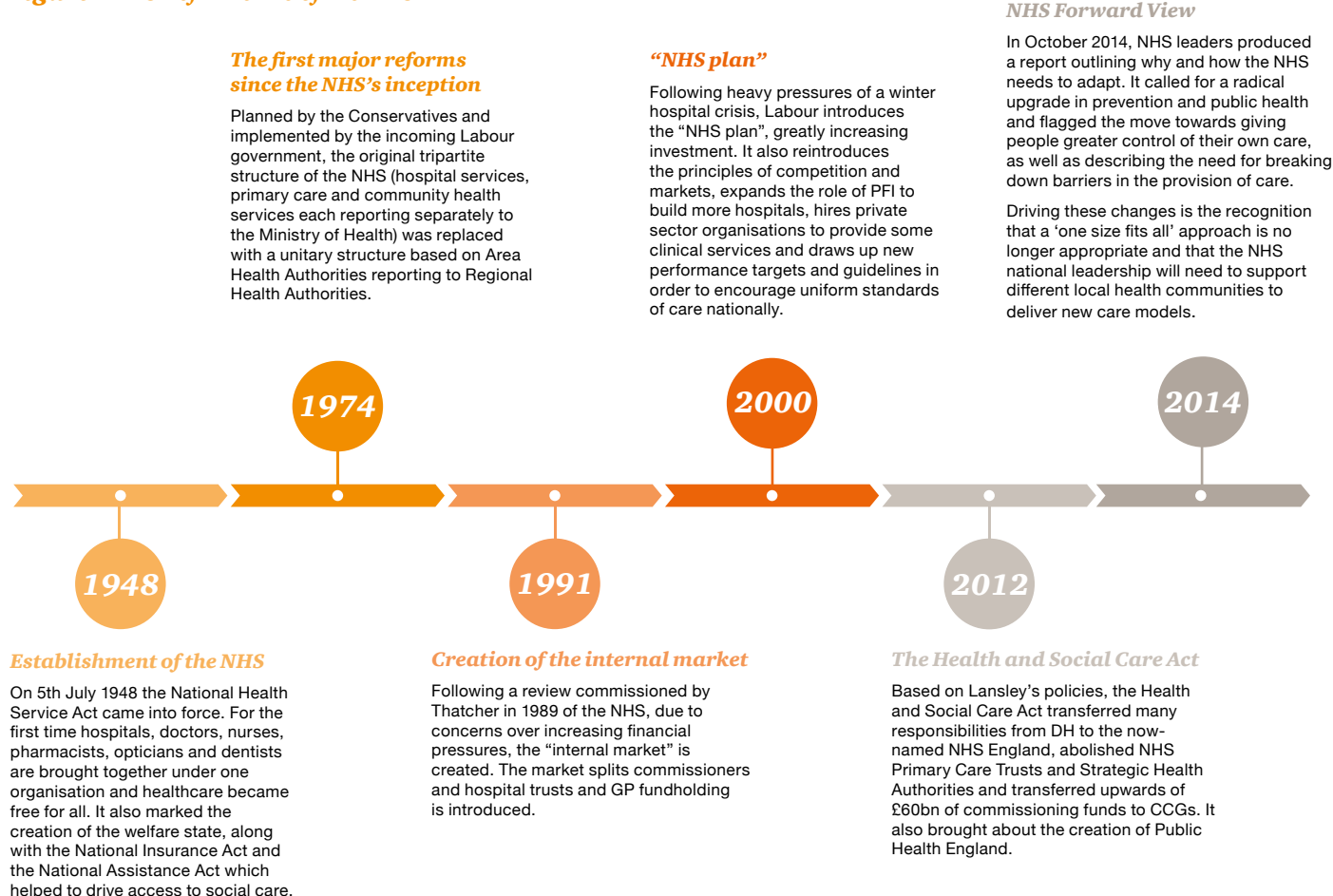
How is the current system performing?

The evolution of today's care system

Since its inception, our country's care system has had both national and local dimensions. The National Health Service was created as a national institution offering a universal service to all UK citizens. That is one of the reasons it is such a source of pride at home and admiration abroad. Yet it is fundamentally a service that is delivered locally – adapting to the particular needs of patients in the local communities it serves. In the case of social care this local dimension is extended further as – unlike the NHS – it is democratically accountable to local people and is part financed through local taxation.

The NHS has been through numerous system reforms since its creation. In designing these reforms policymakers sought to respond to challenges that arose or threatened the service at the time. But they also fought with the inherent tension between the service's national and local roles. As a result, though the overall trajectory has been towards local leadership, there have been periodic swings back towards more centralised control.

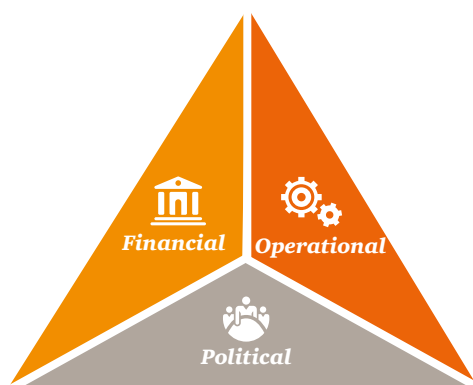
Figure 1: A brief timeline of the NHS



This alternation between periods of national and local leadership has often led to uncertainty as to where accountability should rest in the system. The uncertainty is evident in the differing answers to the following questions:

- Who is responsible for operational decisions that impact on service standards?
- Who is responsible for financial performance?
- Who is responsible for the performance of the system?

Figure 2: The accountability triangle



Tempting as it is to divide the elements of this ‘accountability triangle’ between different organisations and individuals, they are inextricably linked. Operational decisions impact on the performance of the system as a whole; political decisions impact on financial performance; financial performance constrains operational choices.

While there is no single ‘correct’ answer to where each of these responsibilities should lie, failure to align them in the design of the system is likely to undermine its construct.

The 2012 Health and Social Care Act attempted to fundamentally reshape the accountability triangle by delegating responsibility for operational, financial and strategic decisions to local clinical leaders (in CCGs) and replacing central planning with the invisible hand of the market. Indeed, the core principle of the reforms was a desire to liberalise the NHS from its accountability to politicians and national bodies and make local organisations responsible, and answerable to the public, for the delivery of results.

In concept, the 2012 reforms represented a rational way of shaping the accountability triangle. And with time and a fair wind the approach might have been a success. But, from their conception, the reforms failed a series of strategic tests, including:

Political test

Many within the NHS (and perhaps more outside it) were lukewarm about the idea of using market mechanisms to improve services, and publicly took against the reforms during the development of the legislation. To secure the passage of the bill, the government introduced a series of checks and balances into the proposals, which added complexity and blunted their principal mechanisms.



51% of the public hold the UK Government responsible for NHS workforce shortages.



51% of the public hold the UK Government in Westminster responsible for the NHS funding challenge.



20% of the public hold Doctors, Nurses and other Clinical Staff responsible for the time it takes them to get an appointment with their GP.

Source: Public polling, 2,190 adults living in England, carried out by Opinium 5-8 April 2016.

Capability and culture test

Over time, the NHS has developed a strong command-and-control culture that emphasises following the direction of travel set by leaders and has limited tolerance for risk. This culture has served the NHS remarkably well, but proved to be at odds with a set of reforms that sought to replace national structures with the invisible hand of the market. The new approach required people to work in different ways, which needed a different set of skills and capabilities. Failure to recognise this, and to support local organisations in building or acquiring these capabilities, left a number of incumbents poorly prepared for the dynamics of the market.

Events test

The reforms were introduced just as austerity began to bite in the NHS. At the same time, a number of high-profile failures came to light. Both factors created pressure for the centre to reassert control over individual organisations, and there was limited evidence to suggest that a laissez-faire approach could navigate the service through these choppy waters.

Consequences test

For any market to function effectively there must be strong incentives for organisations and individuals to succeed. There must also be consequences – up to and including exit – for those who fail. While the 2012 reforms did provide mechanisms for regulators to deal with the failure of providers and commissioners, there was significant political and financial resistance to their use. Unable to use the tools provided to them for the purpose, regulators were forced into corrupting other mechanisms in order to intervene and prevent failure.

The failure to pass these tests led officials in the Department of Health (DH) and the national bodies to retreat from the reforms. In the process, a range of measures were introduced to blunt the reforms and reintroduce elements of central control. Political

resistance to further legislation combined with the absence – through the design of the reforms – of a single organisation directly responsible for delivering them meant that these adjustments evolved without an overriding vision and plan. What emerged was a complex middle-ground between central control, devolved decision making and a market-based approach, which requires people in all parts of the service to work around the legislative underpin.

Developments within local health and care systems

In recent years, the health and care system created by the 2012 reforms has struggled to cope with the demands placed on it. This is evident in the financial position of the NHS as a whole, which only just achieved financial balance in 2015 / 16, and in the decline in the performance of key operational standards. The system continues to retain public support but appears ill-prepared to deal with the looming challenges presented by:

1. Changes in patients' health needs

The population of the UK is growing and, perhaps more importantly, is ageing and becoming less healthy. This will result in not only a rise in demand for health and care services generally, but a rise in demand for those particular services that are most costly to provide.

2. Changes in treatments, technologies and care delivery

Developments in technology are bringing about new ways of treating diseases and better ways of organising care. While many of these developments will help the system to do more with less, others will extend the range of conditions we can manage if we are prepared to meet the costs.

3. Changes in preferences and behaviours

Today's population has far higher expectations from its health and care system than the first users in 1948 and even those of 20 years ago. In a world where everyday activities like banking and shopping are available at all times of the day, the public has a growing expectation that the health and care system will provide a full range of services on a 24/7 basis.

People have faith in their hospitals. They feel safe when they get to hospitals – they don't want to wait for five or six hours, but if they have to, they will.

Stakeholder interview



4. Changes in the growth of funding for health services

In the aftermath of the global recession, governments continue to experience budget pressures. This has profound implications for spending growth on both the NHS and social care. Over the course of this spending review the government plans to increase NHS spending by just 0.9% per year, while social care spending is expected to be flat in real terms.⁴

The Forward View is rightly clear that simply muddling on in the face of these challenges is unsustainable. The likely result would be:

- stalled progress on life expectancy and a widening of the inequality gap – ‘the health and wellbeing gap’;
- an increase in the gap between the healthcare provided to citizens in the UK and the rest of the developed world, as well as the persistence of unacceptable variations in care – ‘the care and quality gap’; and / or
- an increase in service rationing or financial deficits – ‘the funding and efficiency gap’.

Instead, the Forward View challenges local systems to undergo a transformational journey and secure the long-term future of a taxpayer-funded service. This vision can be summarised in five key principles:

1. Wellness focused

The rise in the number of people living with long-term medical conditions requires a shift in focus away from a system which is reactive, towards one which supports people in reducing the risk of developing these conditions and managing them effectively when they do.

2. Truly integrated and system led

Increasing numbers of people dealing with multiple conditions, coupled with an ageing and less cohesive society, necessitates a multidisciplinary approach to care, and a health system that reduces duplication and enhances efficacy.

3. Learning and adopting

The NHS must learn from successful health systems across the world and share findings and approaches more quickly.

4. Productive and efficient

Reducing variations in both the use of resources within hospitals and those in clinical pathways across the system is vital. Equally, there are substantial clinical and financial benefits in delivering low acuity care locally, outside of NHS institutions, while consolidating high acuity activity in regional centres.

⁴ The Health Foundation, The Kings Fund and the Nuffield Trust (2015) The Spending Review: what does it mean for health and social care?

5. Well-funded and resourced

Securing the overall funding envelope and investing in principal resources (especially labour) are both vital components of a sustainable health and care system. Since 2001 governments of all sides have recognised the need to invest in and ring fence the NHS budget. As a result, the share of public spending devoted to the NHS has risen from 5.08% in 2001 to 7.32% in 2015.⁵

The Forward View is remarkable in two important regards. First, it is the only time a comprehensive plan for the health and care system has been developed by the service itself rather than one being imposed on it. Second, and almost certainly as a consequence of the first, there is a widespread consensus about the plan.

As a result, across the country, local health and local government leaders have come together to develop strategies and plans that deliver on these principles to bring improvements in quality, performance and finance.

Figure 3: Current national architecture of the health and care system in England

The Department of Health (DH)

DH is the ministerial department responsible for government policy on health and care matters in England. The 2012 Health and Social Care Act transferred many of the department's previous responsibilities to other public bodies, such as NHSE and NHI. As a result, its role is now less focused on the daily management of health and care in England. Instead, it has more of a steering function with respect to the bodies it mandates, making legislative changes and, more recently, acting as a stronger champion for patient safety.

The Department for Communities and Local Government (DCLG)

The provision of social care services is the responsibility of local authorities. DCLG allocates government funding for those services to local authorities, who supplement it with funds from a variety of sources such as council tax, central government grant and the Better Care Fund.

NHS England (NHSE)

Originally known as the NHS Commissioning Board, NHSE manages around £98bn of the NHS budget on behalf of the DH. It directly commissions and manages specialist services, offender care, armed forces healthcare, and a large proportion of primary care services, as well as allocating funding to Clinical Commissioning Groups (CCGs).

The National Institute for Health and Care Excellence (NICE)

NICE is responsible for providing advice on the most appropriate practices for delivering health and social care. This role includes producing guidance for commissioners and practitioners, developing quality standards and metrics to measure performance on those standards and conducting assessments of new technologies and pharmaceuticals to assess both safety and value for money.

The national architecture

While the Forward View has made great progress in setting out how services need to evolve locally, policymakers have paid relatively little attention to the construct of national bodies that have been established to support, challenge and guide local systems.

Consequently the 'national architecture' of the service still reflects a system designed to oversee separate NHS commissioners, providers, and local government organisations. This is a complex landscape where responsibility for the national oversight of local systems is divided between a number of different organisations (see Figure 3 below). It is also a landscape that is potentially at odds with the demands of local systems. Through our research we sought to explore whether this was the case, what impact it was having and whether reform was necessary.

The Care Quality Commission (CQC)

CQC oversees the clinical quality delivered by all health and care providers, including hospitals, GP practices and care homes. CQC monitors, inspects and regulates services to make sure they meet fundamental standards of quality and safety.

NHS Improvement (NHSI)

Formed in April 2016 from the welcome merger of five bodies and parts of existing organisations (of which Monitor and the NHS Trust Development Authority were the most prominent), NHSI is responsible for supporting providers in providing safe, high-quality and sustainable services.

Health Education England (HEE)

HEE fulfils a key role in the development of human resources through its remit to ensure the NHS workforce has the right numbers and skills for the delivery of services throughout the country.

Public Health England (PHE)

PHE's role is to improve the nation's health and wellbeing, reduce inequality and tackle the threat to society from healthcare emergencies. This includes advising and supporting government on how to make the public healthier, protecting the nation's health, preparing for public health emergencies and helping local authorities and the NHS develop the public health system and its specialist workforce.

Other organisations

Supporting the above bodies are a range of different organisations. While they have important roles to play in delivering successful health outcomes, either directly or indirectly, they are less focused on the success of local systems.

⁵ http://www.ukpublicspending.co.uk/spending_chart_2000_2016UKp_15c1li011tcn_10t

⁶ OECD. OECD Health Statistics 2015 Focus on Health Spending. <https://www.oecd.org/health/health-systems/Focus-Health-Spending-2015.pdf>

What are the limitations of the current architecture?

In the course of our research, we identified five issues with the existing construct of national health and care bodies. We also found an emerging consensus that these deficiencies lead to complexity, duplication of effort and constrain the progress of local systems in developing the place-based, integrated health and care systems envisaged by the Forward View. The issues we identified were:

1. A lack of clarity of purpose

Figure 4 shows the overlap in scope and activities of current national bodies. It clearly highlights how the current system has created significant duplication in the functions of different national bodies, particularly between NHSE, NHSI and DH. This means:

- local systems are confused about which national body is providing leadership on each issue;
- issues are progressed by more than one national body resulting in duplication of effort;

Public polling:

30% of NHS staff asked are clear on the role of DH and NHSE whilst only 16% are clear on the role of NHSI.

- issues can fall between the cracks in the remits of national bodies; and
- local systems are confused about when national bodies are in 'support' mode and when they are in 'enforce' mode.

It is evident that many people working within the health and care system have difficulty understanding the role that the DH performs, particularly following the delegation of its functions to national bodies over successive decades.

This confusion often leads to frustration and can be a significant issue in the context of staff turnover and its adverse effects on leadership continuity.

Admirably the care system's leadership is operating increasingly collegiately and collaboratively to overcome these complexities. NHSE, NHSI and the CQC are working hard to align and adjust their regimes to reflect the need for a systems-based approach, and this is reflected in recent planning guidance.

But despite the best efforts of these leaders, there remains too much uncertainty and too little clarity. And too much relies on informal exhortation and collective agreement, rather than formal jurisdiction. This creates space for behaviours at national and local levels that run counter to the spirit of more integrated and devolved systems of care.

Every gap becomes a crevasse that your plans fall through, every overlap becomes a crushing duplication.

Roundtable discussion

”

2. A lack of alignment of structures with objectives

The current national architecture was developed to support the success or turnaround of individual organisations involved in the delivery of health and social care to the public. In this kind of framework it is essential that bodies with supervising and supporting roles develop expertise in managing specific organisations in the delivery chain. But, as national bodies have sought to cluster their expertise in one place and focus only on those specific organisations, they have become less knowledgeable about other aspects of the service.

Today's challenges require a different, placed-based approach that integrates all aspects of health and social care. To support the delivery of the Forward View, local commissioners and providers

Figure 4: Mapping of current national bodies against principal activities

National Body	Role				
	Objectives & standards	Finance	System management / enabling	Securing of critical resources	Failure mitigation
Department of Health	✓	✓	▲	✓	▲
NHSE	✓	✓	✓	▲	✓
NHSI	✓	✓	✓	▲	✓
CQC	✓	▲	▲	▲	✓
PHE	✓	✓	✓	▲	▲
NICE	✓	▲	✓	▲	▲
HEE	▲	▲	▲	✓	▲
Healthwatch England	✓	▲	▲	▲	✓
Ofsted	✓	▲	▲	▲	✓
Competition and Markets Authority	▲	▲	✓	▲	▲

are being asked to put aside their institutional differences and come together in local care systems. While many local systems have grasped this challenge and have begun to adapt their structures and practices, national bodies are trapped in their current form by a combination of legacy and the legislative framework that created them.

Participants in our roundtables felt that the failure of the national architecture to evolve meant that the desired integration at a local level had become separated from the interventions that those on the frontline experience from national organisations. Each national body holds local leaders accountable for the delivery of a range of standards and outcomes.

As a result, a single provider finds itself answerable to, or impacted by, a myriad of national organisations and faces the daunting challenge of managing competing requirements. The CQC instructs NHS providers to invest in service quality, for example; NHSI demands improvements primarily in financial performance; while NHSE expects a shift from acute to community provision.

At the same time, the shift towards integrated and person-centric care means the longstanding division between health and social care looks increasingly anachronistic.

3. Distance between national bodies and local bodies

One of the most common complaints we heard from workers in the system was that national bodies are too isolated from the specific issues faced by local systems since the mid-tier of NHS management (Strategic Health Authorities – previously Regional Health Authorities) were abolished in the 2012 reforms.

This isolation has, in the view of the people we met, led to a lack of sensitivity to local needs and circumstances in the prescriptions developed by national bodies, which has limited their impact. Equally, respondents felt the lack of an aggregator or ‘translator’ of information from national bodies has led different organisations in the same geographical locations to interpret national guidance differently.

4. A lack of alignment of decision making, accountability and management

In our experience, a critical success factor in driving change is the alignment of those making decisions with those responsible for funding them, and those accountable for the consequences.

In the NHS this is hard to achieve. Planning decisions are taken locally, funding is raised nationally, and only a small number of people (including the Secretary of State for Health) are accountable to the public for their decisions. Local authorities, in contrast, in the commissioning and planning of social care and in their broader activities, have much greater alignment between accountability, financial responsibility and operational decision making.

We observe that this alignment of decisions and consequences within local government, by way of a democratic mandate through local elections, has helped local government to respond to its financial challenges with agility. By contrast, changes to local healthcare provision often require lengthy consultation exercises and are subject to judicial review.

The unfortunate turnover of chief executives at the top level causes real problems for the system.

Stakeholder interview

”

Medical and nursing schools need to be brought into the mainstream of NHS planning and involvement mechanisms. Currently they teach for the NHS of old.

Sir John Oldham

National Clinical Lead for Quality and Productivity, Department of Health

”

5. Long-term resource planning

Our final observation is that the critical role of planning and developing the key resources required by local health and care systems (leadership, workforce, infrastructure, information and IT) is fragmented across a number of organisations; no single body is taking a leadership or co-ordinating role. This arrangement lacks co-ordination between the various bodies and risks critical issues falling between the remits of different organisations.

Is there a case for stability?

Before embarking on the development of options to address the deficiencies we identified, we considered whether the status quo was the least ‘worst’ outcome and whether, given the enormous financial and performance challenges currently facing the care system, coupled with antipathy towards another round of reorganisation, there is a case for muddling through with the current architecture.

Our conclusion was that, despite the risks, reform of the architecture is necessary. This view stems from two roots:

- First, structures always create incentives for individual behaviours. Failure to align structures with the direction of travel will inevitably create incentives for individuals to drive towards suboptimal outcomes.
- Second, those interviewed at a regional level were consistent in their view that the incongruence between the local direction of travel and the design of the national system creates significant inefficiency at all levels of the care system. There is an emerging view that the current organisational alignment is constraining the vital changes required at a local level.

Staff polling:

71% of NHS staff would like to see the national structure reformed.

Staff polling:

Only **1%** of NHS staff strongly agreed that national bodies work well together to support delivery of local services.

The acceptance or promotion of out-dated behaviours stifles progress. Instead we must encourage and reward behaviours that deliver quality and improvement to the benefit of patients and service-users

Professor David Haslam
Chair, National Institute for Health
and Care Excellence

”

So what now?

We believe there is a strong and urgent need to reform the national architecture to redress:

- misalignment between national bodies' remits and the objectives of the local system;
- duplication and complication of tasks across different national bodies;
- a lack of clarity over the role of the DH and the hierarchy of organisations beneath it;
- an imbalance between political accountability, financial responsibility and operational control;
- an unhelpful gap between national and local levels; and
- the lack of an organisation responsible for securing and developing critical resources required by local systems to deliver over the long term.

While our polling of staff suggests there is a growing appetite for a reorganisation of the national architecture, we are not naive enough to imagine there is a silver-bullet solution to these issues. Indeed, we recognise that there are likely to be compromises and trade-offs to consider along the way. Equally, we recognise that the solutions we develop should build on the system's current direction of travel as well as developments in the external political environment (including the devolution agenda which is at the heart of the current government's strategy for public services).

In the chapter that follows we set out a way we believe policymakers could seek to make progress, highlighting the trade-offs and compromises that our solution would entail.

The national system is really confused at the minute and we've got lots of people working in other people's territories, filling space they shouldn't fill, and generating work and confusion, at a national and local level, so we need a very serious tidying up process.

Jim Mackey
Chief Executive, NHS Improvement

”



What do the public think?

To get a sense of how the current system is viewed by the people who use it, we conducted a poll of 2,190 adults living in England. Our key findings were:

We heard that the NHS should be a genuinely national service and here is mixed support for more local accountability.



The jury is out on the issue of devolving health and social care to local areas; only a third (**30%**) agreed that people should be able to decide what standard of services should be prioritised in their local area. A similar proportion (**35%**) disagreed.

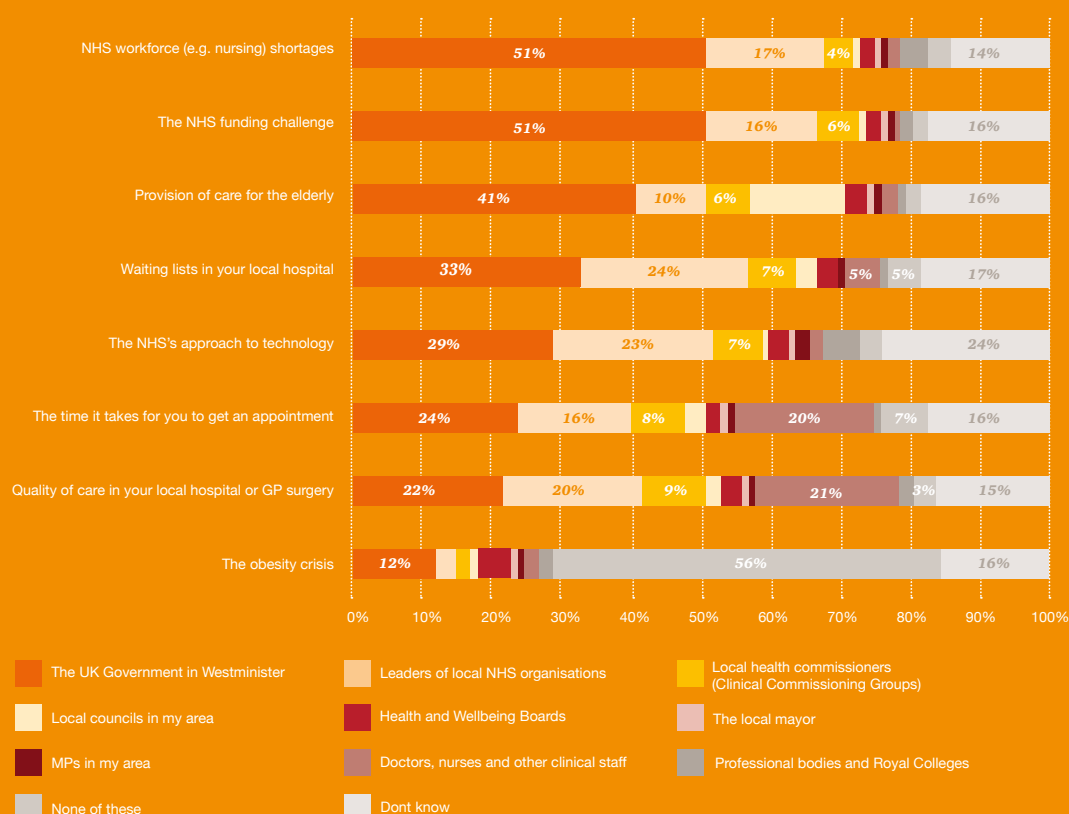


84% felt that quality standards and access to specialist treatment should be consistent nationally.

82% agreed that charging for the care of vulnerable and older people should be consistent across England.

In the public's view, central government is accountable for most aspects of health and care.

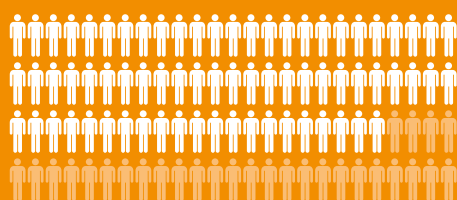
Figure 5: Public polling – who is held most responsible for...



⁷ Public polling, 2,190 adults living in England, carried out by Opinium 5-8 April 2016.

What do those working in the system think?

We wanted to understand how the current system feels to the people who work in it and carry out leadership roles for it. This would inform our thinking on how the current national system performs and potential options for the future. We surveyed 1,230 clinicians from a range of services, conducted six roundtable events and 11 interviews with senior current or recently retired system leaders. Our key findings are:⁸



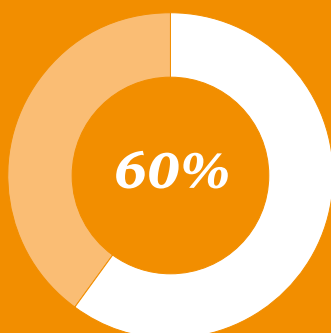
71% said they would like to see the national structure reformed.



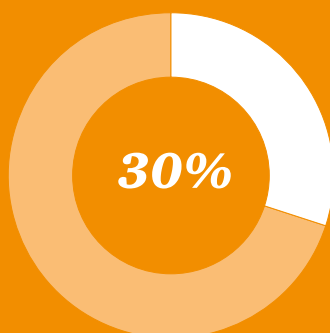
1% of NHS staff strongly agreed that national bodies work well together to support delivery of local services.



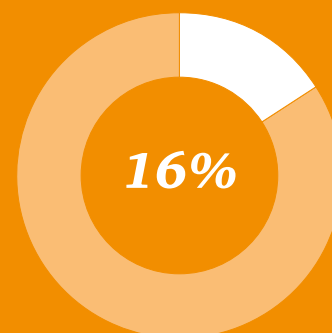
There is confusion among NHS staff over the responsibilities of the various national bodies.



60% are clear on the role of CQC and NICE

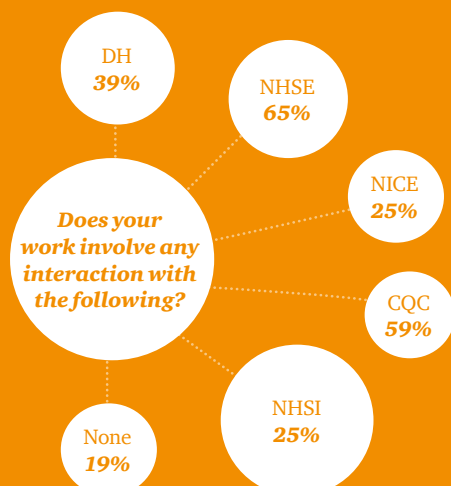


30% are clear on the role of DH and NHSE

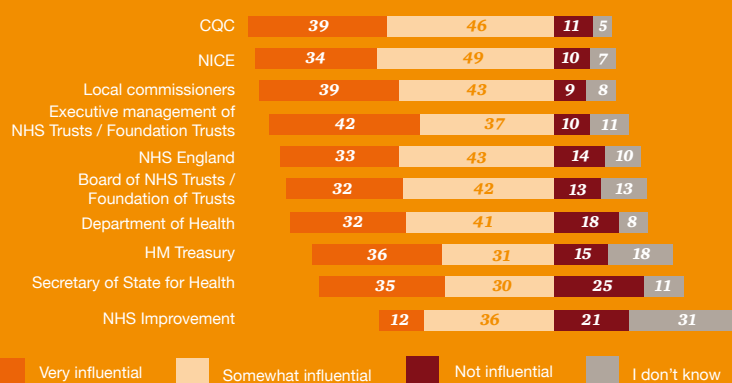


16% are clear on the role of NHSI

The influence that different organisations are perceived to have in day-to-day operations varies significantly.



How influential for the day-to-day operations of the NHS are the following decision-makers?



⁸NHS polling, 1,230 NHS staff in England, carried out by Dods Research, May 2016.

What are the alternatives to the current system?

Approach to developing recommendations

In developing alternative approaches to the current system, we were conscious of the need to keep six potentially competing factors in mind:

1. **change should build on what is already working well** – the strengths of the current system must be retained;
2. **immediate organisational upheaval is a risk** to a system struggling with profound performance and financial issues;
3. **the current national architecture is slowly evolving** and it makes sense to align reform with the direction of that evolution;
4. **the transition to local integrated care systems will take time** and necessitate a very different architecture to the one we have now;
5. **some aspects of the infrastructure are fixed** – functions such as setting strategic objectives, determining policy and securing the majority of funding are likely to remain the domain of government;
6. **the architecture must be coherent** – piecemeal changes and ‘pick and mix’ approaches risk creating a complex architecture that lacks overall coherence.

If you're integrating locally, you should be integrating at a national level.

Stakeholder interview



We are therefore proposing a two-stage approach which aligns with the journey that the health and care system has begun:

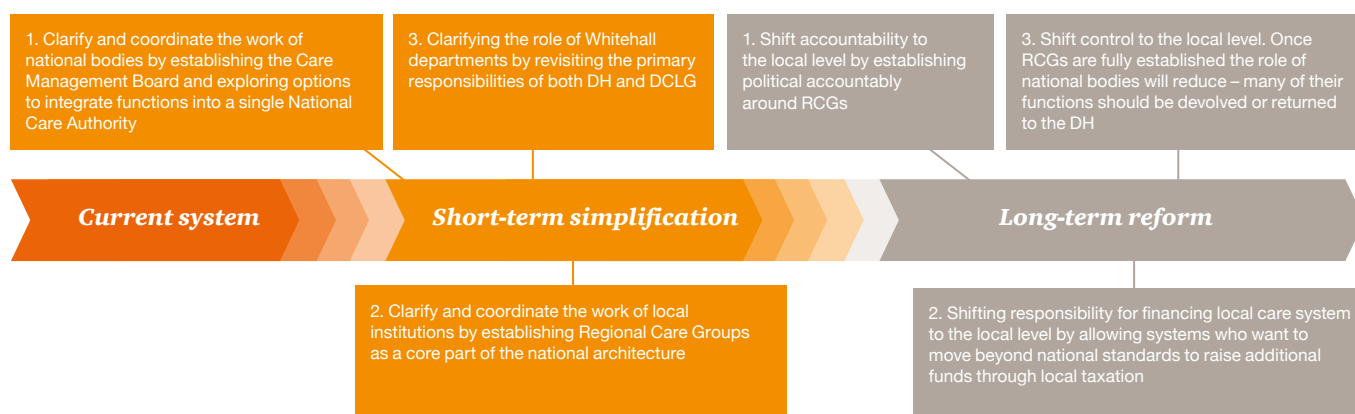
1. The first stage – **‘simplification’** – focuses on short-term evolutionary changes to clarify the roles and responsibilities of national bodies and better align them with the needs of local systems. This stage will enable better working in the delegation of power from national to local bodies in line with the Forward View;
2. The second stage – **‘reform’** – builds on the simplification stage to unequivocally change the balance of power within the care system and clarify its ambiguities through more meaningful devolution of accountability, control and financing to local areas.

This two-stage process recognises there are imminent challenges facing the current system that must be addressed. But, ultimately, this approach aims to evolve the national architecture to support the longer-term sustainability of the health and care system.

While, it will undoubtedly take time to reach our proposed end point, setting a firm direction of travel now means policymakers can provide a clear roadmap of change. That in itself will bring greater clarity and certainty to the care system.

In the following section we discuss the key features of both stages and consider the limitations of our proposals.

Figure 5: Development of the simplified architecture and the devolved architecture





To use a sporting analogy, the role of national bodies is to set the rules including the shape and size of the pitch. It is not their role to referee every game or, worse, to play. What they do shapes the game that is played and the degree to which the crowd thinks it is successful.

Dame Gill Morgan
Chair, NHS Providers



Short-term simplification

In the simplification stage, we propose increasing and formalising co-ordination between key national bodies and clarifying and co-ordinating the role of local institutions and Whitehall departments.

We have to connect local government with the local NHS, because they're both concerned with people and place.

Duncan Selbie
Chief Executive, Public Health England



The single most critical thing national bodies can do is to make sure that they don't come up with policies that lead to confusion, duplication and unintended consequences.

Professor David Haslam
Chair, National Institute for Health and Care Excellence



Proposal 1. Clarify and co-ordinate the work of national bodies

In the previous section, we described the lack of co-ordination among national bodies and confusion about their roles. Creating a single point of authority within the health and care system therefore presents obvious benefits. But it requires careful consideration, particularly regarding the cost, risk and likely upheaval incurred during a reorganisation. In this context we are recommending a more organic, evolutionary set of changes, minimising the immediate disruption to the system but building towards substantive long-term change.

a) Establishing a Care Management Board as a first step

A potentially quick and cost-effective first step would be to establish a Care Management Board (CMB) to co-ordinate the policy and activity of its constituent organisations in supporting, challenging and directing local systems to achieve the standards and objectives set by the centre.

The CMB would consist of the chief executives and chairs of NHSE, NHSI, Public Health England, and Health Education England (HEE). It would also include representatives from social care to ensure alignment across the system. The principal role of the CMB would be to ensure its member organisations operate coherently in supporting, challenging and directing local systems to achieve the standards and deliver the objectives set by Whitehall departments. The CMB would also be responsible for setting the strategic direction for the NHS and the wider care system.

To deliver these priorities, we believe the CMB should:

- **be chaired by somebody from outside the current national bodies.** This could be a new appointment or, in the interests of strengthening the role of Whitehall departments, be undertaken by the Permanent Secretary of the Department of Health.
- **be appropriately constituted and governed.** This means there should be a clear remit, regular meetings, transparent reporting, and follow through on actions and agreements.
- **be able to direct the boards of any of its member organisations.** Should the CMB feel that one of its member boards is not acting in the best interests of patients, it should have authority to overrule a decision taken by the member and provide that body with a revised course of action.
- **support its member organisations in making joint appointments at regional level.** To reduce duplication and misalignment at a regional level, we believe the CMB should encourage NHSE and NHSI to make joint appointments in their regional teams.

An important omission from the formal membership of the CMB is the CQC. While we would suggest that representatives of the CQC attend the CMB, it is important that the CQC is, and is seen to be, an independent inspector of care services, rather than being within the chain of command of the very system it is tasked with inspecting.

b) Further co-ordination through targeted reorganisations

Building on the creation of the CMB, co-ordination could be taken further through system reorganisations. A logical first step would be to subsume the functions of HEE into the work of NHSI. This would meet the urgent need to ensure that providers' requirements are fully informing workforce considerations. HEE is an 'orphan' in the current system architecture, operating without necessary sponsorship or support. This serves to undermine workforce policy and presents risks to the future sustainability of the care system.

c) Creating a single principal delivery agency for the health and care system

A more comprehensive step would be a full reorganisation of the functions of NHSI, NHSE, HEE and the wellness and prevention functions of Public Health England into a National Care Authority (NCA), which would act as a single point of authority and accountability within the health and care system. This approach

presents obvious key benefits, not least a reduction in the number of national organisations, aligned rhetoric and action and the prospect of genuine integration across the system.

The principal role of the NCA would be to provide support, guidance and challenge to local systems in delivering the standards and objectives set by Whitehall departments. As a result, it would need to be given a clear remit emphasising its critical role in:

- supporting systems in designing and delivering good value, sustainable, effective and safe services in both the short and long term;
- supporting systems in becoming experts in prevention and wellness management;
- driving the integration of health and care services and eliminating delivery inefficiencies;
- identifying and evaluating new models of care that support local systems in achieving their objectives;
- developing common tools and approaches (e.g. contracts, reimbursement approaches, financial planning tools, information policies) that can be adapted and deployed by local care systems;
- securing, allocating and developing the critical resources (workforce, capital and information) required by an efficient and world-leading care system;
- protecting the interests of service users and the public through considered application of cooperation and competition measures; and
- monitoring the progress made by local systems against objectives and determining whether, when and how to intervene.

One of the key drawbacks of this approach, notwithstanding the creation of what would undoubtedly be the largest non-departmental body in Whitehall and its probable governance difficulties, would be the significant cost, upheaval and confusion likely during the transition and formation period of the new body. The costs and risks associated with this approach will need careful assessment to determine its viability.

The principle should be that the things that are done at a national level should be the things that can only be done at a national level. When you only centralise what's absolutely necessary, you find that the things you should do at a national level are actually quite small and well defined and then the rest can at least be done on a regional basis.

Stakeholder interview



Proposal 2. Clarify and co-ordinate the role of local institutions

One of the most oft-repeated messages we heard from people working in the health and care system was that the distance between local and national levels has led to a lack of sensitivity to local needs and circumstances in the prescriptions developed by national bodies. Equally, respondents felt the lack of an aggregator or 'translator' of information from national bodies has led different organisations in the same geographical locations to interpret national guidance differently. The result is confusion and inefficiency.

To overcome this communication deficiency, we suggest NHSE establish a mid-tier within its organisational structure whose role would be to co-ordinate and translate national requirements into each local context. This tier would also be tasked with ensuring local systems deliver maximum value for the resources delegated to them. Such a reform is aligned with the recent direction of travel seen in the delegation of funding to Greater Manchester and, in particular, in the establishment of the 44 STP footprints. However, the mid-tier we propose is intended to be a more permanent structure, designed to oversee the delivery of system planning and management with delegated resources.

The specific remit of organisations in this tier – potentially called Regional Care Groups (RCGs) – would be to:

- assume strategic responsibility for the delivery of national standards and value for money for their populations;
- co-ordinate planning and transformation within and between organisations;
- take responsibility for public health, primary care and specialist commissioning;
- aggregate routine health and social care commissioning across their geographies where it is in the interests of the system to do so; and
- resolve key local issues between providers and commissioners to deliver an integrated health and care system for service users.

Creating an additional administrative layer within the system presents a risk of increasing the burden on the exchequer or diverting resources away from the front line. We believe this can be avoided if RCGs are implemented effectively, ensuring that common functions currently undertaken by area teams, CCGs, and councils are appropriately consolidated within RCGs. If done carefully, this reform could reduce costs by removing duplication and increasing economies of scale.

Could the simplification stage lead to financial savings?

We estimate that the aggregation of commissioning activities by RCGs could save at least a third (£380m) of the current £1.139bn administration spend of CCGs nationally and a quarter (£111m) of the £443m combined annual running costs of NHSE and NHSI.

The savings assumption in respect of commissioning activity spend is based on an evolution away from the existing national architecture of 211 CCGs towards an aggregated RCG model comparable in terms of numbers with the existing 44 national STP footprints.

NHSE and NHSI are already demonstrating their ability to work collaboratively and it is reasonable to assume that a continuation of this approach within a coherent and formally aligned national architecture that reduces duplication will lead to operating cost savings.

Sources:

1. NHS England Annual Report 2015 / 16 – Funding to group bodies (Admin) £1.139bn; 1/3rd of total – £380m.
2. NHS England Annual Report 2015 / 15 – Operating expenditure £319m (less CCG admin expenditure); Monitor annual report and accounts 2015 / 16 – Staff costs £49.23m, Other expenditure £14.76m; NHS Trust Development Authority annual report and accounts 2015 / 16 – Staff costs £27.09m, Purchase of goods and services £10.79m, Other operating expenditure £21.71m. Total expenditure across three organisations – £442.58m; ¼ of total – £110.65m.

We've got to be far more disciplined about the interaction between standard setting and the resource implication that that does or doesn't have.

Stakeholder interview



STPs are what appear to be a small step but actually in my view are a much more significant strategy change.

Stakeholder interview



Could STPs evolve into RCGs?

In December 2015, NHSE and NHSI issued instructions requiring local health and care commissioners to come together with the major providers of care to form one of 44 'STP footprints', and develop a plan for how local services will transform to deliver on the vision of the Forward View.

While NHSE and NHSI have frequently said that the role of the STP footprints is not to enhance or replace local NHS bodies, both have taken steps to prolong the footprints' presence and enhance their role. This has included issuing a range of guidance for STPs, developing STP-level allocations and control totals for the next two years, and enhancing the provider operating framework to align individual providers with the activities of their local STP footprint.

Given that STPs already exist, and that steps are being taken to give them a long-term role, the idea that they should simply morph into our proposed RCGs may seem superficially attractive. We believe such a simplistic solution would be a mistake and would risk reinforcing some of the failings of the STPs we have observed. We don't believe it is enough for the RCG tier to act simply at a planning level, one which temporarily bridges the gap between the current fragmented state and a genuinely integrated way of working. Nor should it be just another layer of strategic planning bureaucracy disconnected from and lacking influence over the day-to-day activities of the system.

The STP would be the place that care organisations might be accountable because of that local connection, that local political connection.

Stakeholder interview



Instead, we set out a collection of principles that should govern the formation of RCGs:

- **RCG areas should be aligned with current administrative boundaries wherever possible.** This will mean that RCGs would operate within a familiar geography, their boundaries would be well defined, and there would be genuine alignment with adult social care, as well as a direct link to democratic accountability and a potential reduction in the number of local decision makers.
- **Scale and patient flow must be taken into account.** Where alignment with existing administrative bodies would create incongruence with patient flow and the location of acute providers, or is inappropriate for other reasons, an RCG should be able to straddle two or more administrative districts.

- **The size of RCGs should facilitate quick decision making.**

While RCGs need to be large enough to undertake their activities properly, the question of whether there are too many organisations to be engaged or consulted needs to be considered.

- **Local relationships should be considered.** There would need to be consideration as to whether these relationships are based around individuals or organisations, and reinforced appropriately.

In many areas, the above principles are likely to lead to a continuation of the STP geography. In others, where STPs are poorly aligned to patient flows or are not delivering tangible benefits, new geographical configurations will need to emerge.

To allow RCGs to undertake their roles, we believe a number of changes are required which represent important differences from the STP model. These include:

- **Giving RCGs sufficient resources.** Effective RCGs will need to secure a more substantial and sustainable resource base than the STP footprints currently have access to. RCGs should therefore take over the resources allocated to local area teams and should have power to top-slice CCG budgets.
- **Giving RCGs power to assume responsibility for commissioning.** Our research revealed how the current commissioning base is often too small to implement and manage the accountable care organisations envisaged by the Forward View. RCGs should therefore be tasked with ensuring commissioning is undertaken effectively and efficiently in their geographies and should be able to assume commissioning responsibilities when beneficial to the local population.
- **Giving RCGs responsibility for primary care and specialist commissioning.** Responsibility for the commissioning and performance management of primary care currently lies outside of the control of local systems. We believe the responsibilities for primary care commissioning should be transferred from local area teams to RCGs. Similarly, we believe RCGs should assume primary responsibility for specialist commissioning in their areas. If RCGs feel they could benefit from collaborating with other regions, they should be given the freedom to do so.

Proposal 3. Clarify and co-ordinate the role of Whitehall departments

Finally, we believe there is an urgent need to rearticulate and clarify the role of the DH and the Department for Communities and Local Government (DCLG) within the health and social care system. This is poorly understood at present, both within national bodies and beyond, as demonstrated by our polling of NHS staff and the public.

We believe the government should clarify that the principal role of Whitehall departments in delivering thriving local care systems should be to:

- **Determine the common objectives, standards and targets that the system in England must achieve within a funding settlement period.** In our view, the system would benefit from having a single, stable and simple set of objectives developed by Whitehall departments that are aligned to financial settlements.

- **Secure the resources required by the system to deliver its objectives.** Having set the objectives, Whitehall departments must secure the financial resources (revenue and capital) to deliver them.
- **Ensure organisations within the system are given the powers and levers they need, and are held accountable for using them.** Whitehall departments should ensure their agents are given the necessary legislative authority and practical resources to undertake their roles, and are held to account for their actions.
- **Champion innovation and improvement. Departments have a critical role to play as the public's agent for change within the system.** They should therefore continue to press the system (e.g. through the CMB) to explore new technologies and new ways of working that can improve the service for those who use it and those who fund it.
- **Explore the potential synergies between the social care element of the Local Government and Social Care Ombudsman's role and the regulatory functions of the DH, NHSI and NHSE.**

In many ways this remit is not that far removed from the DH's current role. But there are two fundamental differences that are critical to the success of the system:

1. **Our proposed remit clarifies the role of Whitehall departments in setting clear objectives for the health and care system at large.**
2. **Our proposed remit emphasises the system management role of Whitehall departments.** This encompasses holding delivery authorities to account for their activities and ensuring the system delivers for patients and taxpayers

Beyond the above three proposed changes, the current system (including the roles of other national bodies like CQC, NICE and MHRA, NHS Digital, NIB and NQB) would remain unchanged. Equally, to ensure a focus on both the delivery of business as usual and progress towards the Forward View, we recommend the statutory roles and functions of local organisations should remain as they are today. Following the simplification stage, they will continue to operate under a delegated system in which the balance of accountability, control and financing remains with national rather than local bodies.



Limitations of the short-term simplification stage

While we believe there are numerous positive changes that can be achieved at the simplification stage, we recognise there are clear limitations:

1. Reorganising national bodies will be a distraction

The simplification stage would undeniably require a significant change process to bring about the new organisations and ways of working we envisage. That said, most of the changes formalise trends already happening in the health and care system and recognising them in a staged manner is unlikely to be unduly disruptive. Most importantly, the changes will end the duplication and confusion that local systems currently encounter.

2. Simplification is something of a compromise solution

The simplification stage represents what we believe is achievable within the current political settlement for the health and care system. As such, while it addresses some of the system's deficiencies, it leaves others unresolved:

- a. It fails to fully overcome the incentives for local and national organisations to work in silos. The model is likely to maintain incentives for different organisations to take different approaches and thus compromise reform.
- b. It fails to make much progress in aligning political accountability, financial responsibility and operational control. Both political accountability and financial responsibility remain with the national bodies, which is likely to mean they become directly involved in operational planning and delivery assignments.
- c. An NCA would be a very large organisation incorporating multiple functions and tiers. Although this would remove the current duplication of functions and create clearer lines of accountability for place-based systems, the body would likely need a complex operating structure to oversee its functions and tiers, and hold local systems accountable. The optimum balance of functions between the national and RCG intermediate level would need careful consideration.



Longer-term reform

The simplification stage addresses some of the key challenges in the current system in the short term. But we believe there is an opportunity to go further over the next decade. A longer-term reform which moves from a segregated and delegated system to an integrated and devolved model will take time and need careful implementation. But we believe it is the logical next step and critically it can address two key unresolved issues:

- it would overcome the artificial division between health and social care and create a truly integrated care service; and
- it would unequivocally change the balance of power within the care system through more meaningful devolution of political accountability, financial responsibility and operational control to local areas.

We suggest three further changes to bring about this vision:

1. **Shifting accountability for the management of health and social care to the local level.** Local political accountability should be established around RCGs in the form of directly elected mayors, such as those in London and Greater Manchester, combined local authorities or the creation of new political institutions.
2. **Shifting responsibility for financing local care systems to the local level.** Those responsible for designing and delivering services should be given the function of managing health and care finances.
3. **Shifting control over health and social care to the local level.** The commissioning of health and social care should be integrated in a single function at local level.

It makes sense to integrate budgets and focus on developing local capability. We need to get the balance right between top down and bottom up innovation.

Jim Easton
Managing Director, Health Care, Care UK ””

Proposal 1. Shifting accountability to the local level

We believe that in order to break the stranglehold exercised by Whitehall on the NHS and unblock the reconfiguration process accountability for healthcare must be devolved from the national to the local level. We therefore believe that RCGs should evolve into democratically accountable local bodies over the next decade, assuming responsibility for the integrated commissioning of health and social care.

But creating a local democratic body for health and social care is a complex process. It requires consideration of three issues:

1. the level at which democratic accountability should apply (neighbourhood, local, regional, super-regional);
2. the form of democracy that should apply (should accountability rest with a single individual or with a number of elected individuals?); and
3. whether there are existing structures that could take on the role.

On the first issue we are firmly of the view that the benefits of establishing RCGs would be undermined if equivalent political accountability was at anything other than the RCG level.

However, the process of devolution will require flexibility: different parts of the country should be able to evolve in different ways. We believe RCGs and relevant local authorities should be free to propose to national government the form that local accountability should take depending on their particular circumstances.

A number of possible accountability structures are outlined below, along with their advantages and drawbacks.

There has to be somewhere where the people responsible for commissioning and providing come together and are held to account; the Monday morning meetings just don't cut it.

Stakeholder interview ””

Figure 6: Advantages and drawbacks of accountability structures

Option	Advantages	Disadvantages
Building on local authority representation	<ul style="list-style-type: none"> • Well established structure and democratic process • Accountability understood and acknowledged by the public • Well placed at a local level to integrate health and care with other public services 	<ul style="list-style-type: none"> • RCGs' geographical remits could potentially contain many local authorities. Some form of amalgamation or representation would then be required, which could take time to achieve or risk undermining the democratic principle • Risk of being too well established, meaning change could take a long time • Less control over health and social care overall due to the wider scope of local authority responsibility
Adapting regional mayors or police commissioners	<ul style="list-style-type: none"> • Relatively new roles, with posts being merged together, making them easier to adapt • Similar footprints to STPs or potential RCGs • Potential for integration with other public services; could form the vehicle for other services that are not currently hosted by any authorities 	<ul style="list-style-type: none"> • Remit may be too broad, risking either health and social care becoming the dominant focus at the expense of other priorities, or a diminishing focus on health and social care • Regional mayor coverage across the country is currently limited • Outside London, voter turnout has been disappointing • May lack subject expertise
Creating a new democratically accountable body or position	<ul style="list-style-type: none"> • Can be designed to be specific to health and social care • Can be built around the new RCG platforms • Can require expertise in health and social care from the start 	<ul style="list-style-type: none"> • Establishing a new role and political process can take a long time • Risk that another elected body / official could further dilute engagement of voters • May lack other necessary capabilities and relationships (including political engagement) • Lack of integration with other public services

We should significantly move away from a tariff based mechanism for funding much of the healthcare system and actually we should break the funding silos between health care and social care.

Stakeholder interview

Proposal 2. Shifting responsibility for financing local care systems to the local level

Unlike social care, which is part funded nationally and part locally, the funding of local health services relies on decisions at the national level. National bodies – mainly HM Treasury, the DH and NHSE – determine who gets what. The transition from a delegated to a devolved model requires that this responsibility shift to local care systems.

I don't think we have devolution. I think we have delegation. Devolution implies that the whole thing goes out...accountability...and that's not happening.

Sir John Oldham
National Clinical Lead for Quality and Productivity, Department of Health

A possible solution is to make local, rather than national, taxation the means of funding integrated care systems. But this would entail huge upheaval, create massive inequity and call into

question the very idea of a national health and care service. That is not what we propose. Instead, we suggest two main changes:

a) Greater local flexibility and responsibility for managing health and social care finances

We believe the resources allocated by central and local government for health and social care should be made available to RCGs to deliver on their objectives. This is in keeping with a more devolved health and social care system, and the direction of travel we set out at the simplification stage. RCG leaders should be held accountable for delivering national outcomes from this budget and should be subject to full scrutiny over how those resources are used.

The system of CCG allocations and the national tariff should cease to apply to devolved regions. Instead, RCGs, supported by NHSE and NHSI, should be able to review how resources are allocated between localities within their areas and determine how to reimburse providers for their activities.

The other power that I believe is critical to devolve... is the power to raise money...for me you only get real accountability if at least some of the money is raised at the same level that it is being spent at...I've argued for a dedicated health and care tax raised nationally, but with the power in a locality for this to be varied.

Rt. Hon. Norman Lamb



b) Greater local flexibility to source additional health and social care funding

Some communities will elect leaders who support ambitious reforms or outcomes for local health services. Others will elect leaders who support the preservation of the status quo, even if it means spending more money. In such a world, we believe those leaders should have the means to supplement national allocations with additional funding from local sources.

In the short term, the social care precept provides a platform to build such a mechanism. Over time, it may need to be amended to allow RCG leaders to determine its level and where any additional burden should lie. This could ultimately result in a restructuring of council tax to allow RCG leaders to draw together all additional local resources dedicated to health and social care into a single transparent levy for the local population.

We have to let go...of many of the detailed control mechanisms that exist today; and make it very clear that the accountability lies in local health economies

Stakeholder interview



Proposal 3. Shifting control to the local level

The move from a delegated model to a devolution model will need time for capabilities and structures to be built. Each local system should be free to take on the responsibilities of the devolution model when they can demonstrate they have the necessary capacity, skills and processes in place.

However, the process will mean a significant shift of control from national bodies to local levels. This would require two key changes: true integration of commissioning at a local level and giving the local system powers of intervention over all aspects of the local health and care system.

a) Integrating local commissioning

The logical conclusion of current policy is, as many have already identified, that CCGs and local authorities come together as single commissioning entities. There are various models for achieving this, including:

- CCGs commissioning social care and public health services on behalf of local authorities;
- local authorities commissioning healthcare services on behalf of CCGs;
- establishing a joint commissioning function to act for both organisations;
- a statutory transfer of the functions of CCGs to local authorities; or
- a transfer of some or all commissioning responsibilities to the RCG level.

Given the variation in local relationships around the country and the different skills and capabilities of the teams involved, we believe national bodies should not prescribe any one of these models over any other. Instead, we suggest Whitehall departments create the necessary mechanisms to enable any of these models to be adopted, and task each local system to work towards whichever it feels is most appropriate for its circumstances.

An essential requirement of each model will be retaining access to the expertise of local clinical leaders to help shape commissioning strategies and actions. This could be achieved by electing clinicians as members of local authorities, creating distinct roles for clinical experts on the executive bodies of RCGs or reinvigorating the scrutiny role of health and wellbeing boards.

b) Devolving powers to intervene in all aspects of the health and care system

At the simplification stage we propose that NHSE's current intervention powers over CCGs be passed to RCGs. At the reform stage we think most of NHS's intervention powers should also be transferred to RCGs. This would include all powers relating to a breach of licence conditions and the ability to place a provider into special measures. The only powers we suggest should remain at a national level are the ability to place a provider into a failure regime and the power to dissolve a trust.

Implications of our longer-term reform for the current system

While not the direct focus of our work, it is clear that our reform proposals will have notable implications for the health and social care landscape in England. These are set out below:

CCGs

The advent of RCGs would represent a fork in the road for CCGs as the primary commissioners of health services. In the medium term, we would expect CCGs to transform away from their initial strategic commissioning function. Some might expand to become RCGs. Others may seek a future as a local clinical advisory body to their local RCG, working in partnership with health and wellbeing boards. Consequently, the functions currently performed by the CSUs will need to adapt to the new commissioning structure.

Local authorities

The implications for local authorities are likely to be as diverse as the range of local structures that may come about through the RCGs. We expect them to fall into two camps:

1. In areas where the local authority does not become the accountable body for health and social care, the relevant funding, operations and responsibilities would be moved elsewhere within the local system.
2. In other areas, local authorities, or combined local authorities, could take on a key role as the primary accountable body, with an expanded responsibility for health as well as social care. Funding models would change: the health and social care budget would need to be transparently ring-fenced from other areas of expenditure, rather than forming part of the local government financial allocation from DCLG.

Provider trusts and foundation trusts

Provider trusts and foundation trusts would not be directly impacted by either the simplification stage or the reform stage. But they would be indirectly impacted. In the simplification stage, providers would be jointly accountable to NHSI and their local system. At the reform stage, providers would be responsible for the delivery of targets and standards set by their local RCG, which, in turn, would be subject to the delivery of national standards and the remit given to it by the local electorate. This would benefit providers, as performance would be given greater context.

The Secretary of State

The Secretary of State for Health will be impacted by the adaptation of the role and remit of the DH at the simplification stage. The reform stage has broader consequences. While there will remain a responsibility and accountability to Parliament, the alignment of operational control, democratic accountability and financial responsibility in RCGs would create clearer boundaries between the roles and obligations of central government and locally accountable bodies. This would reduce the operational focus of the Secretary of State and allow him or her to focus on championing the interests of patients and taxpayers.

The DH and DCLG

At the simplification stage we propose aligning these two government departments. But we believe responsibility for health and social care should ultimately be consolidated within a single government department, the Department of Health and Care, to ensure the integration of funding and organisations at all levels in the care system. The simplest way for this to be effected is for social care funding to go directly from DH to local authorities, thereby ring-fencing social care funding from the wider local government financial settlement overseen by DCLG and eliminating the role of DCLG in the oversight of social care.

Other national bodies

Shifting responsibility from the national to the local level will allow the rationalisation of national bodies. It is likely that the CQC will continue as a separate organisation to provide independent inspection and regulation functions. Similarly, NICE will continue as the independent setter of national standards. But NHSE and NHSI will be slimmed down and merged, with their successor body either remaining at arms-length or absorbed into a single Department of Health and Care.

National payment system

A national payment system is unlikely to remain relevant if RCGs are successful in designing genuinely local population-focused health and care systems. In such a case, the role of NHSE and NHSI in setting national prices is likely to diminish over time. But the collection and sharing of cost information that currently supports the national tariff-setting process would likely remain in place, and there may be a role in developing and championing innovative or model reimbursement approaches. NHSI would need to take on a new role of developing an approach to govern 'out of area' activity, where patients receive services outside the areas in which they are normally resident. And rules would be needed for the governance and funding of complex specialist services centred in regional tertiary centres. Finally, where financial disputes occur within the system, NHSI would need to retain an arbitration role.

Competition policy

Competition and patient choice are not directly impacted by either the simplification stage or the reform stage. But the general move towards a diversity of place-based, consensual strategic plans creates a risk of monopolistic systems developing in some areas. It would be incumbent on locally accountable bodies to ensure patient choice was not compromised and that these arrangements were properly established and monitored. NHSI and NHSE would have a role in advising local systems on the implications of their actions for patient choice, and investigating and correcting anti-competitive or inefficient behaviour.

Further reductions in the scale and scope of national bodies

As more RCGs take on financial and political accountability for all aspects of health and social care the case for maintaining a strong centre is diminished.

As depicted in Figure 7, we believe that if capable and accountable organisations are established at RCG level, the roles of national bodies would be limited to distributing financial resources (revenue and capital) to RCGs, supporting strategic planning, and managing requests from local systems to place provider organisations into administration or to dissolve them. Given that these activities align closely with the strategic responsibilities of Whitehall departments we think that, at the point at which the vast majority of local systems assume fully devolved status, the functions of these bodies should be reintegrated with those of our proposed Department of Health and Care.

Figure 7: Transfer of core functions under the reform stage

NCA / NHSE & NHSI core functions	Destination in reform model
Allocation of resources	Returned to DH&C
Stimulating innovation	Returned to DH&C
Supporting strategic planning	Devolved to RCG level organisations
Developing initial critical resources and tools	Devolved to RCG level organisations
Performance management of local systems	Delivered through political accountability
Intervention in failing systems	Delivered through political accountability
Hosting RCGs	N/A

Limitations of our longer-term reform proposal

Our proposal for the longer term reform tackles some fundamental barriers in the current system with the aim of aligning accountability, delivery and finance. However, we acknowledge that there are a number of key challenges that would need to be addressed:

1. The degree of change may be politically unpalatable

We understand this view but believe that policymakers need to consider the implications of both the ‘do nothing’ and the compromise approaches. There is a wide consensus for change among NHS staff. Further, the pressures on the system will make its current configuration unsustainable in the future. We believe reform of the architecture is a critical enabler of change. It will reduce both confusion and complexity and truly empower local leaders.

2. Delegating responsibility will undermine the ‘N’ in the NHS

While devolution necessarily means local systems move away from a ‘one size fits all’ approach, we do not believe it means moving away from a common set of standards and commitments. Our proposed model strengthens the role of national bodies in determining these standards and retains a number of the critical elements of a national service (including NICE to provide direction on funding approved drugs and CQC to provide national quality regulation). Most importantly, the NHS would remain free at the point of use.

Nothing that has been put in place would actually solve the financial deficit within the timeframes which you would need it to, and the worry would be if this approach to whole economies actually becomes derailed, because somebody comes in and says, ‘oh, this hasn’t worked, let’s change it.

Sir John Oldham
National Clinical Lead for Quality and Productivity, Department of Health

3. Integrating health and social care at a local level will undermine the principle of universality

The argument that bringing healthcare (a universal service funded by general taxation) together with social care (a means-tested and geographically variable service) under the control of local government would inevitably lead to a differential rationing of the NHS is a strong one.

But our view is that the counterfactual scenario represented by the current settlement is leading towards a very similar outcome by stealth. While some localities are investing in social care to maintain or expand provision, others are cutting back to balance the books. In these latter localities the lack of social care support has resulted in increasingly full hospitals which, in turn, have led to falling performance, increased deficits and the cancellation or rationalisation of services. Under the current system, decisions on social care are being made without accountability for their impact on healthcare.

Our approach crystalizes an issue and debate that should be taking place. It provides levers for local leaders to wrestle with the issues, be judged on their success under a single performance framework and be held accountable to the public for their decisions and achievements.

4. Using the current council tax structure will exaggerate its flaws

Council tax is widely acknowledged⁸ to be a suboptimal system of local taxation and its flaws have been discussed at length. Some of our interviewees commented that expanding such a system would place it under undue strain and would further exaggerate its imperfections. We have some sympathy with this view, but reject the notion that current flaws should prevent the use of an established system of administering local taxation. Rather, we see our proposed expansion as an opportunity to reform a vital element of local democracy that is not fit for purpose.⁹

Supporting local systems in moving from delegation to devolution

Our longer-term reform proposals present an opportunity to correct some of the ambiguities of the current system through a significant transfer of powers and responsibilities from the national to the local level.

It is the alignment of operational control, funding and accountability that differentiates a genuinely devolved system from a delegated one.

If the reforms are to be successful, local systems will need to spend time building capabilities and structures, both within RCGs and, more importantly, across the entire system. This is likely to take time. Furthermore, different systems will move at different speeds in adopting the model, depending on their current capabilities and structures and the political environment within which they operate.

What the public have to accept is that if you are devolving, then inevitably you're going to have variation of the way that people handle that.

Stakeholder interview



It's unlikely that you'll find an elected member knocking on a door of a constituent and saying 'guess what, we've created a single integrated commissioning vehicle, now vote for me'. So it's important that the notion of integrated commissioning is always described in the context of the difference it will make to the health and wellbeing of local people. Using population outcome based language, is more likely to be something that elected members can get behind.

Owen Williams
Chief Executive, Calderdale and
Huddersfield NHS Foundation Trust



We would expect NHSE to have a significant role to play in supporting the development of these new organisations, applying the lessons learnt from CCGs authorisation, and the process of Foundation Trust (FT) authorisation delivered by NHSI's predecessors.

⁸<https://www.sundaypost.com/news/scottish-news/expert-view-council-tax-is-flawed/>, http://blog.moneysavingexpert.com/2011/04/01/council-tax-20-years-since-it-was-valued-a-flawed-system-no-ones-brave-enough-to-sort-out/?_ga=1.28572348.1211830410.1472119286, <http://www.isitfair.co.uk/Reports/Public/LGA%20Beyond%20the%20Black%20Hole.pdf>, <http://www.isitfair.co.uk/Reports/Public/escape-from-council-tax.pdf>

⁹While our recommendations here focus on council tax (41% of local government revenue), we are also supporting a major programme of research into local government finance led by the IFS which will consider the implications of business rate retention and further fiscal devolution.

Next steps

Our country's health and care system has been transformed over time. Functions once the preserve of the DH have been delegated to NHSE, NHSI, NICE and the CQC. Powers that were once exercised nationally have been delegated to NHS Trusts, NHS Foundation Trusts and local commissioners. More recently, local authorities have joined the journey through embryonic local integrated care systems. These are welcome developments.

We believe the opportunity exists to take the care system to the next stage of its journey.

In this document, we have sought to start a debate by bringing to the fore a significant issue facing the health and social care system in England. We have offered a diagnosis of the shortcomings of the status quo and suggested a way forward that we believe will put the national bodies of the NHS in a better position to support local health systems in dealing with the challenges they face.

However, we have stopped short of prescribing a detailed timeline or roadmap for implementing our proposals. We expect that our devolution recommendations, or something like them, would require at least ten years of careful debate, planning and implementation. They would require a consensus within the service and across political parties. A broad and engaged debate on these issues is now of paramount importance. It should gain the varying perspectives of patients, clinicians, managers, policymakers, regulators and academics.

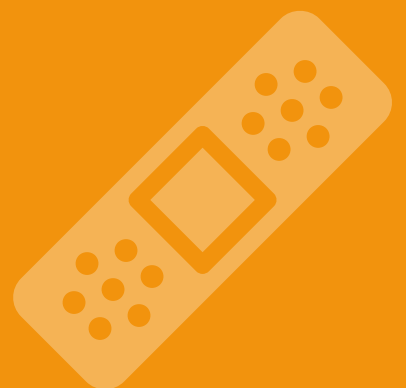
The recent moves to consolidate the functions of Monitor and the NHS Trust Development Authority under the single banner of NHSI, and the creation of STPs, may represent the first steps towards the consolidation of national bodies and the creation of place-based strategic planning. This kind

of working across organisational boundaries and formal structures should continue. In the fullness of time the changes will need to be formalised in law. But we suggest that a target end state be agreed before embarking on legislative reform. It is therefore important that the debate about the future structure of the NHS does not fall to the bottom of the pile, behind day-to-day firefighting in a service where growth in demand for care outstrips growth in funding.

Finally, a focus must be maintained on the ultimate objectives of the service. Reform of the national architecture should be undertaken with the purpose of supporting, not hindering, local systems in developing resilient, sustainable, high-quality care services that safeguard the needs of patients well into the future. The prize will be a better co-ordinated system. A system that works with reduced bureaucratic constraints, organisational barriers and competing incentives. And a system with a greater ability to focus resources towards the front line in a way that best fits the needs of local populations and the users of care services.

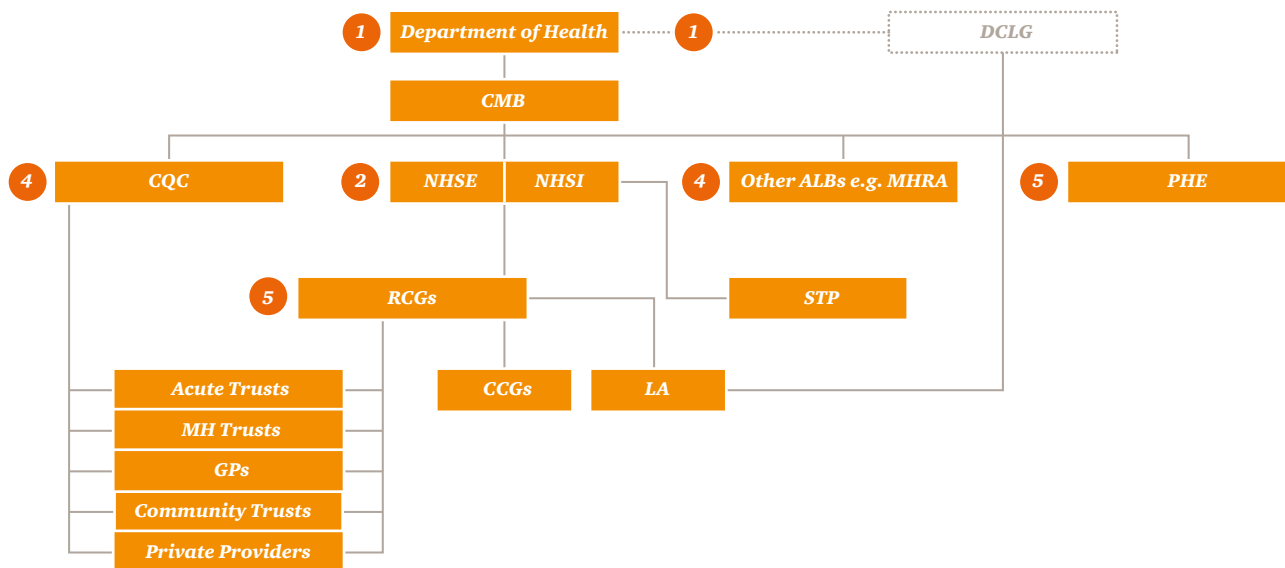


Appendix



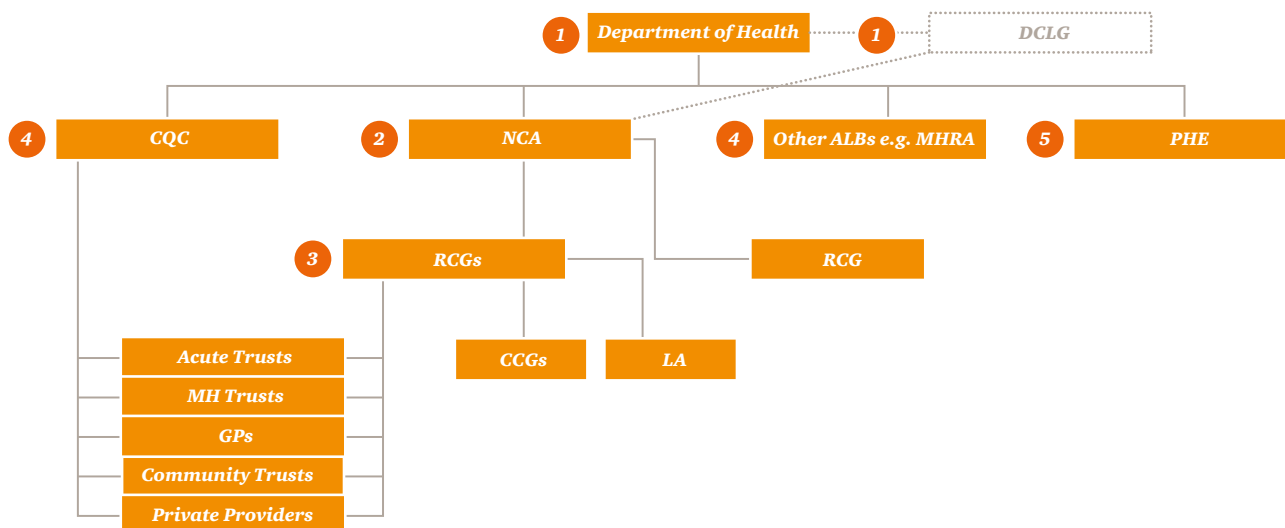
Revised national architecture models under our proposals

Figure 16: The revised national architecture following creation of a Care Management Board (CMB)



1. Responsible for setting national standards, securing resources required by the system, empowering ALBs and championing improvement and innovation.
2. Responsible for supporting local and national standards, supporting strategic plan, developing tools and approach, developing critical resources, allocating resources.
3. Responsible for delivery of national standards, efficient use of resources locally, development of local organisation capability and capacity, co-ordination of planning and responsibility for commissioning of primary care and specialist care.
4. Unchanged responsibility.
5. Transfer of prevention and wellness funding to RCG.

Figure 17: The revised national architecture following creation of a National Care Authority (NCA)



1. Responsible for setting national standards, securing resources required by the system, empowering ALBs and championing improvement and innovation.
2. Responsible for supporting local and national standards, supporting strategic plan, developing tools and approach, developing critical resources, allocating resources.
3. Responsible for delivery of national standards, efficient use of resources locally, development of local organisation capability and capacity, co-ordination of planning and responsibility for commissioning of primary care and specialist care.
4. Unchanged responsibility.
5. Transfer of prevention and wellness funding to NCA.

Figure 18: The national architecture in an emerging reform model

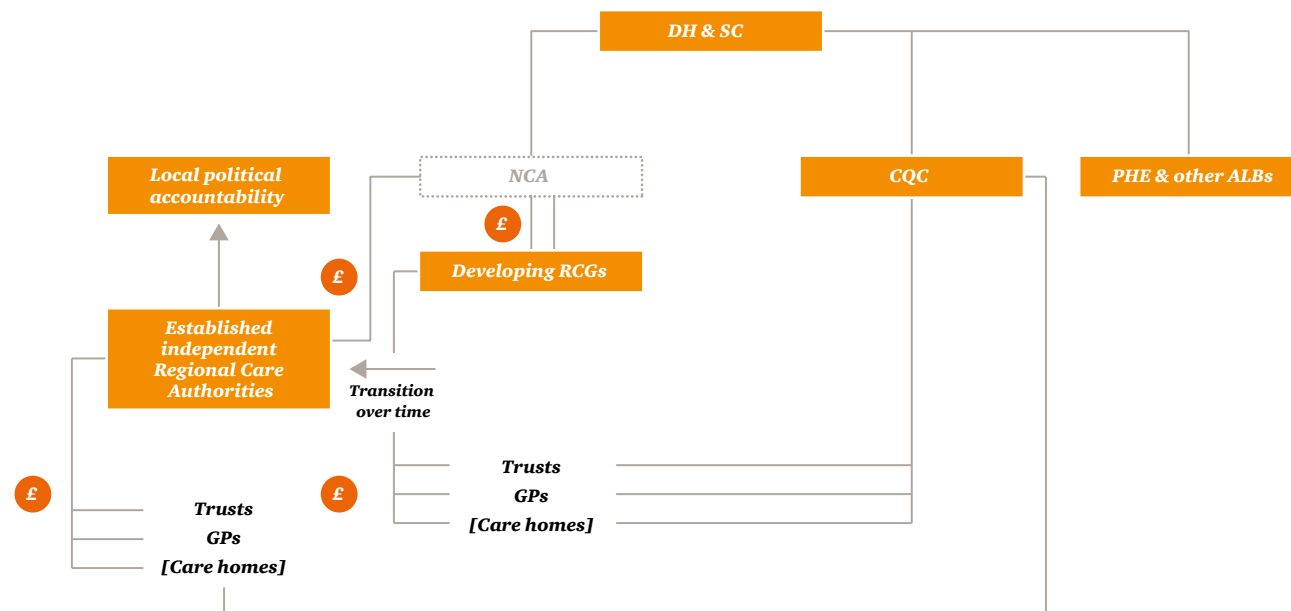
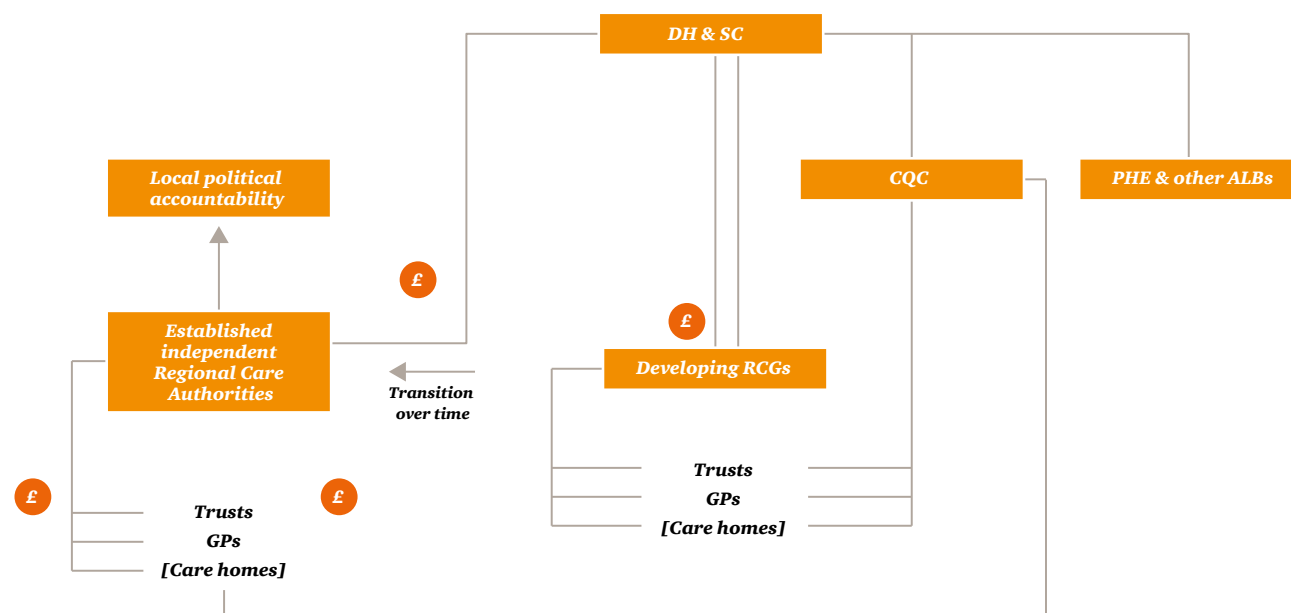


Figure 19: The national architecture in a mature reform model



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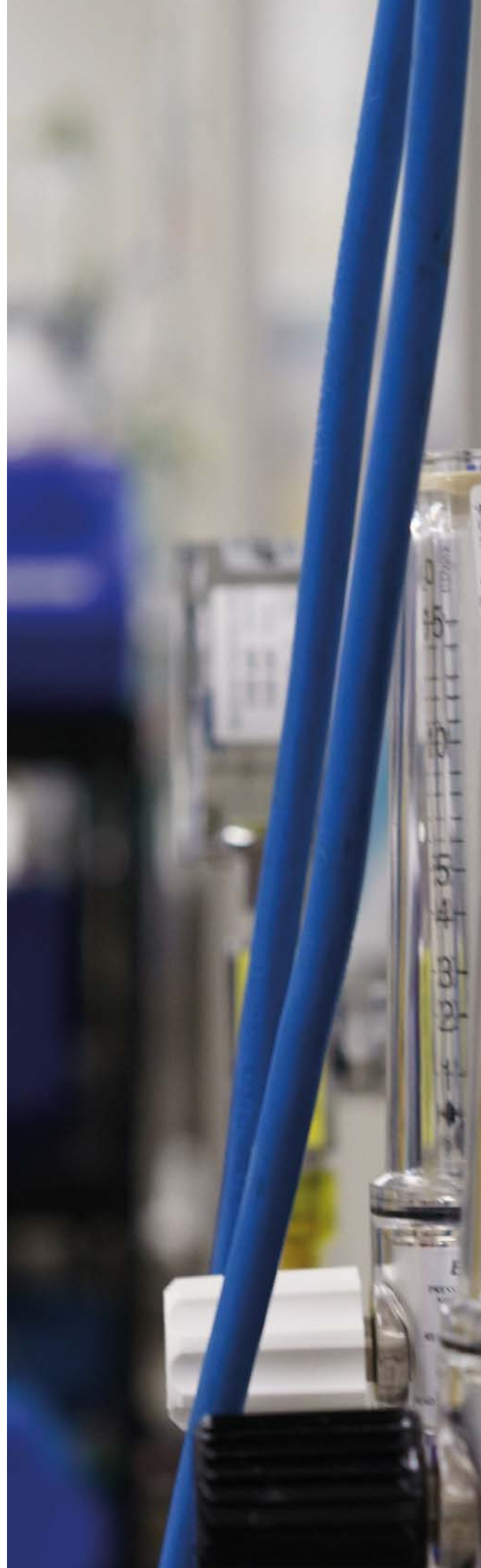
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Tomorrow's healthcare today

Healthcare matters to us and it matters to our clients. We all want better healthcare, sooner and the potential is there to make it happen. New technology, new breakthroughs, new ideas. But while there are opportunities, there are challenges too: constrained budgets, an ageing population and an increase in chronic conditions. At PwC we're working with clients to steer a course to success in this new health economy so we help improve healthcare for all.

We're working with the NHS, nationally and locally, as well as the private sector and the pharmaceutical and life sciences sector to deliver real, workable solutions to today's challenges. We're delivering transformation and integration projects with patient outcomes at their heart. And we're supporting organisations through testing financial times, often developing bespoke operational and digital systems. We give strategic support to organisations across healthcare and pride ourselves on convening different parts of the system to solve problems.

We also bring insight and expertise to healthcare as well as engaging in the public policy debate. For more information, sign up for our Health Matters blog at:

www.pwc.blogs.com/health_matters

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