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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

Espresso summary

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The context

The health and care system is rightly a source of national pride in our country. But the service today is under significant financial and operational pressures, both of which are set to increase. The challenge these pressures present to the future sustainability of the health and care system are immense. Across the country local providers and commissioners have embraced these challenges and are developing their plans for addressing them in line with the call to action set out in the Five Year Forward View (the 'Forward View').

However, to date there has been little attention paid to the role of national structures in enabling local systems to deliver. In recognition of this gap we commissioned research to explore what the public and staff working within the NHS thought of the national architecture of the health and care system and to examine what changes were required to better support local systems in delivering sustainable services in their areas[1].

Our findings

The current national architecture of the health and care system is a complex middle-ground between central control, devolved decision making and a market-based approach, which has failed to keep pace with the direction of travel of local systems. During the course of our research we identified five areas for improvement that together add complexity, lead to duplication, and frequently hinder the progress local leaders are seeking to make. These are:

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

Our findings were echoed by polling of staff and the public which found:

- widespread confusion over the role of national bodies among NHS staff: a large majority of senior staff 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 employees (66%) identified the division between health and social care as a barrier to delivering the 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%); and
- a growing appetite for reform: more than 70% of NHS staff felt there was a need for change to the current system and only 11% felt that current arrangements were effective.

Our recommendations

We propose a two stage approach to resolving these architectural deficiencies. 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. The second stage – 'reform' – builds on the simplification stage to enable a truly sustainable, fully devolved and integrated health and care service.

Short-term simplification

The priority for the short-term is 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 we make are consistent with the current direction of travel and, could result in an efficiency saving of up to £0.5[2] billion annually.

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.

Co-ordination could then be taken further through a targeted reorganisation. Our first step would be to merge HEE into NHSI. This could be followed by 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).

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

There is no permanent function that currently performs the role of co-ordinating local institutions or translating national requirements into local actions. We suggest that NHSE delegate responsibility for improving standards and managing resources, and strategic planning across health and social care to Regional Care Groups (RCGs) which should emerge from the Sustainability and Transformation Planning (STP) footprints.

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

The government should make it explicit that the primary responsibility of DH should be the improvement of the health of the population through the strategic oversight of the care system.

[1]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.

This does not mean running or managing the system. Rather, it means ensuring co-ordination between the constituent parts of the national architecture. To ensure better co-ordination between the DH and DCLG, we suggest they have a shared objective to act together to facilitate evolution towards a single care system in England.

Longer-term reform

Beyond the short-term changes, we believe that there is an opportunity to unequivocally change the balance of power in the care system and resolve current ambiguities through more meaningful devolution of accountability, control and financing to local areas. Again, we suggest three reforms:

1. Shifting accountability to the local level

RCGs should evolve into democratically accountable local bodies and assume responsibility for the integrated commissioning of health and social care. Alongside relevant local authorities, they should also be free to propose to national government the form that local accountability should take in their areas.

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

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 local taxation to draw together all additional local resources dedicated to health and social care into a single transparent levy to supplement national funding.

3. Shifting control to the local level

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.

Conclusion

We intend our work to form a platform from which a discussion with policymakers, local leaders and frontline staff can begin, to proactively plan for the future system architecture of our care service.

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 would move towards local areas as they assume greater accountability for the financing and control of services.

Establishing this new system will require carefully phased changes to the architecture of the system and will take time to enact. By setting a firm direction of travel now policymakers can provide a clear roadmap of change. That in itself will help bring greater certainty to the care system.

[2]We estimate that the aggregation of commissioning activities by Regional Care Groups (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).

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