PRUComm evidence relevant to current White Paper on legislative change in the NHS

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Note based upon research evidence derived from PRUComm and other studies and from our own and colleagues' experience of working within the NHS.

Background
The current NHSE legislative proposals represent a profound change to the way that services have previously been overseen and planned. As discussed previously, PRUComm colleagues are concerned about the lack of detail and the failure to explain how current functions will be carried out in the new system, as well as the effects on accountability of the proposals.

This note aims to summarise the main issues we think the proposals raise.

1. NHS history – the role of planning authorities

Throughout the history of the NHS there has been a key role for some degree of regional governance. While governance structures, specific responsibilities and functions have changed over time some key roles have remained constant. In particular the regional organisation has been seen as a necessary co-ordinating layer between the centre and the periphery, maintaining a degree of balance (between providers, commissioners etc) in local systems (Lorne et al 2019).

Through each reform of the NHS since 1948 it has been recognised that acute providers – especially large teaching trusts – will have a dominant position. It is in part in order to limit this provider dominance that the NHS has always had a body with system planning and oversight functions at some scale below national and above local health economies. This function has been backed up by regulatory frameworks and structures.

Regional Health Authorities (1974-1996) and their successors, Health Authorities (1982-96) and Strategic Health Authorities (2002 -2012) had a number of governance functions including balancing regional finances, resource allocation, moving surpluses and deficits between providers and between commissioners and providers. A key role was planning – taking an overview and limiting provider dominance. In particular these bodies, engaged with other local agencies such as local authorities, translated national policy priorities into a framework for each region by producing regional plans and ensure their implementation; undertook strategic population planning; created strategic frameworks for local services; and provided (post 1992) strategic direction and oversight of the local workings of the internal market.

The regional bodies also "held the ring", providing independent system governance. While there was some ambiguity about the power of boards and managers to do this, RHAs and SHAs played an important role in holding purchasers and providers to account. Each of these authorities had a statutory board predominantly formed from the authority senior directors, external non-executives and an independent chair.

As statutory "corporate bodies" these boards did not involve provider managers and therefore were seen as independent of local providers and were tasked to take a broader view and hold services to account. With the introduction of the internal market these regional organisations exercised a regulatory function for both purchasers and providers. When established in 2002 SHAs were given an overall responsibility for 'system management' to hold the local health service to account. This essential principle of accountability and governance independent from direct service provision has been seen as a key principle in previous reforms at the regional level.

2. *Role, responsibilities and accountability of Integrated Care Systems*

The introduction of the concept of Sustainability and Transformation Partnerships and later Integrated Care Systems to replace the sub-regional tier of authority abolished by the 2012 Act has been welcomed by the NHS given the need for coordination at this level set out above. The current legislative proposals set out in the White Paper of February 2021 which indicate that ICSs will be statutory bodies is welcome, as it can obviate a complex series of work arounds being used by the current non statutory ICS and STP groupings (Lorne et al, 2019).

There is, however, a series of important issues to resolve in respect of the new ICS statutory bodies:

- The division of functions between ICSs and their lower tiers of administration have not been clarified. Place level is stated to be the tier at which most decisions will be made, but there is currently insufficient detail about which tier should carry out which function. (We make some observations and suggestions about place level activities in the section on CCG current functions below, including our view that places, as well as ICSs, need guidance on their governance structures.)
- There is no indication about how decisions will be taken in the event of disagreement between members, nor how ICSs' decisions can be guaranteed to be taken in the interests of patients, as opposed to providers. It is envisaged that local NHS bodies will be members of ICSs, and it seems to have been assumed that these bodies will be able to reach a consensus which will facilitate the improvement of patient and population health and wellbeing. There is no evidence to suggest that consensus of the required type can and will be reached. Indeed, previous experience shows that it is often necessary for there to be a final decision making body which is able to impose a solution on conflicting organisations (Klein, 2013).
- More generally, there has been no guidance about the formal governance of ICSs, such as how decisions will be made. Will each member organisation have one vote? If so, the variability in the number and type of NHS organisation in each ICS will affect the balance of power.
- Conflicts of interest are likely to arise as NHS organisations are being tasked as members of ICSs with making strategic decisions which concern themselves. NHS providers will continue to have obligations to maintain their own financial viability as well as a role in strategic planning. It is likely that these two functions will not always coincide. For example, it might be strategically necessary to reduce hospital funding in order to reallocate resources to out of hospital care in order to improve population health and patient experience, as well as constituting a more efficient use of limited resources. The problem of conflict of interests also indicates the need for a superior decision making body.

While we understand that the legislation and concurrent guidance will tackle some of these issues in due course, ICSs are currently struggling with these issues. Suboptimal decisions (or in fact no strategic decisions) may be being made currently, and too much time is being spent on developing

individually based ICS governance structures, as well as place level arrangements (Sanderson et al, 2021).

3. Primary Care Commissioning

History

At the inception of the NHS in 1948 general practices were established as independent contractors to the NHS. Until the Health and Social Care Act 2012 came into force, a local body of the NHS was responsible for oversight of primary care provision.

In 2012 when PCTs were abolished and replaced by GP-led Clinical Commissioning Groups, responsibility for commissioning and overseeing primary care services went to NHS England. However, it quickly became apparent that such services could not effectively be commissioned at national level, and in 2014 it was proposed that this function should be delegated back to Clinical Commissioning Groups (McDermott et al., 2016). This proved complicated to achieve, because the disruption associated with the Health and Social Care Act 2012 had led to a significant loss of expertise in areas such as primary care estates, contracts and detailed local knowledge of practice strengths and weaknesses (McDermott et al., 2018; McDermott et al., 2019). Moreover, conflicts of interest were an issue which has not been resolved (Moran et al., 2017).

Current roles of CCGs with respect to primary care commissioning

The establishment of Primary Care Networks via an add on Directed Enhanced Service to the General Medical Services contract has given CCGs wide ranging responsibility for oversight and support. Contractually CCGs are responsible for administering a very complicated contract, which has within it a number of funding streams and service requirements (NHS England, 2020b; NHS England, 2020c). It is not within the scope of this short paper to explore these in detail, but in summary CCGs are formally responsible for:

- Overseeing the establishment and running of PCNs, particularly having responsibility to agree configurations and oversee any changes to these. If a practice opts out the CCG is responsible for ensuring that their patients receive services from another PCN
- Overseeing payments for staff recruited under the Additional Roles Reimbursement Scheme (ARRS), and checking that such payments are correctly claimed
- Receiving reports as to employment of staff under the ARRS and submitting these every 6 months to NHS England
- Monitoring PCN performance against service specifications via the Network Dashboard
- Administering payments for other funding streams including: Clinical Director costs; Investment and Impact Funding (incentive scheme – requiring oversight of performance against indicators); extended hours services; and network participation payments.

In addition to these formal responsibilities, we have established that CCGs have taken on a wide range of other support roles, including: providing seconded management staff or funding to support managerial staff; protecting CCGs from demands and brokering local relationships; supporting PCNs in establishing workable inter-practice agreements; and supporting PCNs through disagreements and other local issues (Hammond et al., 2020).

At the same time as administering and monitoring this complex contract, CCGs continue to exercise all their previous functions with respect to primary care commissioning.

This includes:

- overseeing GMS, PMS and APMS contracts;
- overseeing contractual payments associated with the Quality and Outcomes Framework;
- monitoring performance and compliance with respect to these contracts;
- administering other Enhanced Services;
- supporting practices with respect to information systems and electronic patient records;

- supporting practices in trouble, including difficulties in recruiting and managing staff performance;
- managing support contracts for general practices such as specimen collection rounds; and
- overseeing issues with Primary Care Estates, including those associated with PFI contracts.

Primary Care Commissioning as set out in current NHSE Legislative proposals

In November 2020 NHS England published their proposals for changes to NHS structures and accountability relationships (NHS England, 2020a). The headline of these is that they recommend the merging of CCGs to cover the same population as Integrated Care Systems (assumed to be 1-3 million) and their eventual abolition, with their functions passing to new statutory ICSs. The document setting out these proposals does not refer explicitly to primary care commissioning functions. In detailed reading of the document we have identified the following proposals relevant to primary care commissioning:

- It is suggested that new, as yet undefined non-statutory 'place-based partnerships' will: '*support and develop primary care networks (PCNs) which join up primary and community services across local neighbourhoods' (p12)*
- ICS leadership with have '*primary care network representation''* (p13)
- Some functions will be delegated from ICSs to 'place-based collaborations', which will have primary care 'provider leadership' represented (p15), but whether it is envisaged that these delegated functions will include those relevant to primary care commissioning set out above is unclear. Importantly, how such delegation to what is essentially a provider alliance would work is unclear – it seems unlikely that GPs will be keen on their performance being overseen by an alliance of other providers who may have very different visions of what primary care should look like. Potential conflicts of interest are not mentioned
- Primary care budgets will be pooled with other budgets at ICS level (p17). ICS leaders will need to distribute these funds in accordance with '*national rules… such as primary care investment guarantees*'(p18) but it is also suggested that 'resources for general practices' might be delegated to Place level.

Subsequent to the NHS England proposals, the new White Paper does not enlarge on these issues.

Concerns arising from this

- Current proposals do not say anything about who will be responsible for the complex support and oversight responsibilities which have always been a feature of primary care in the NHS. The experiment of carrying out these responsibilities at national level by NHS England in 2012-13 demonstrated that local oversight and knowledge of primary care is required for their efficient management. The establishment of Primary Care Networks is entirely contractually based, and this new contract requires detailed monitoring and oversight which will not be possible at ICS level, where there may be as many as 50 PCNs and 500 or more practices represented.

- The suggestion that primary care budgets will be pooled with other community budgets implies the subsuming of individual practice contracts into some larger entity. Such an arrangement was a centre piece of the Five Year Forward View (NHS England, 2016), but it proved unattractive to GPs and in spite of strenuous attempts to establish a new combined provider organisation in at least one CCG area this has not been possible (Checkland et al., 2019). It therefore seems unlikely that such proposed 'pooling of budgets' will be possible. Indeed, the mechanism chosen to establish PCNs (a DES contract) explicitly makes such a pooling more difficult, as the money associated with PCNs is ring-fenced to support practices according to the terms of the contract.

- Finally, overseeing multiple small providers of primary care services – even when they are successfully working together across larger areas in networks – requires detailed local knowledge and trusting relationships, as well as skilled brokerage to support collaboration. It is concerning that current proposals do not recognise this and contain no proposals for any body or organisation to provide this support. The PCN cannot provide this as it itself is the body which requires support and oversight. Non-statutory provider alliances at Place level will have substantial conflicts of interest and it is hard to imagine how such alliances could undertake the functions currently undertaken by CCGs. If these proposals go ahead this will be the first time since the establishment of the NHS that there has been no local support and oversight for primary care, apart from the short time between 2012 and 2014.

4. The wider roles of CCGs – operational commissioning responsibilities

Current roles of CCGs

The current draft of the White Paper as published in late February 2021 contains very little detail beyond saying that the 'majority' of CCG functions will be transferred to the proposed ICS board. In considering what the impact of the proposals might be it is important to consider what those functions are, and which organisations might take over those functions in the new system.

CCGs currently have a statutory role in procuring services and managing contracts. They hold a budget, and are responsible for allocating that budget in order to procure services for a geographical population. They are also responsible for the oversight of quality, and discharge this function via contract oversight and management, and for ensuring patient and public involvement in decision making. These legal responsibilities are set out here. However, beyond these statutory functions, CCGs have a broad range of operational roles within local place-level health economies. It is important that these are explored, their utility interrogated and the geographical scale over which they need to be carried out considered, because there is a danger that if they are not specified they will be forgotten.

1. Service redesign and instigation and coordination of change

CCG commissioners have broad expertise in service redesign and coordination of change across a range of providers. Importantly, they have an overview of local health systems, and understand the specific relationships between the different place-level providers of care which need to work together to deliver care pathways and to improve population health. CCGs and their predecessor commissioning organisations have played a key role in planning and implementing changes in the configuration of services in their local health economies. Especially in cases where services are to be transferred from one provider to another, it has rarely proved possible for providers to achieve this type of change without a local commissioner leading it (Allen et al, 2015; Osipovic et al, 2017).The coordinating role of commissioners includes liaising between primary, secondary, community and local authority services and ensuring that changes proposed in one part of the system do not adversely affect other. Local health economies are complex and varied, often due to particular historical legacies; locally based managers with a good understanding of the local care landscape are therefore essential in this process.

2. Brokerage and conflict resolution

As statutory budget holders CCGs are well-placed to act as brokers when there are disputes as to how services should be designed or managed. For example, differing priorities might lead a community services provider to propose service changes which would impact negatively on local primary care or social care providers. CCGs are well placed to broker agreements that try to optimise

outcomes for all parties which protect the interests of patients. Whilst ideally agreement will be reached by negotiation between managers who know and trust one another, if agreement cannot be reached, CCGs as commissioners can impose a solution using their statutory powers. The evidence suggests that alliance contracts have not yet proved to be a successful mechanism for providers to forestall or resolve these types of conflicts (Sanderson et al, 2019).

3. Management of support services

The provision of high quality services over a local geography requires high quality general support services. This might include: contracts for sample collection from local provider sites; an overview of local estates and ability to broker mutually supportive relationships around their use; local support for organisations struggling due to staff sickness; or support for staff management and recruitment.

4. Supporting failing services

When services get into real trouble they need a locally-based oversight body with responsibility to support them and ensure continuity of services. Whilst responsibility for service continuity can be vested in the ICS level, there will need to be a local organisation with a detailed knowledge of place-based services to ensure that service continuity is operationalised appropriately.

5. Day to day operational support for the system as a whole

Currently CCGs have 'on call' managers who have a detailed knowledge of the whole system locally. These managers can step in if a particular service is close to being overwhelmed (e.g. A&E capacity or emergency admissions) and broker supportive arrangements, divert patients escalate to the next level and communicate with primary care. This role has proved particularly salient during the COVID pandemic when coordination of day to day operations has been vital to keep services going in very difficult times.

6. Primary care commissioning

See paragraph above. This is an important place-level role that needs to be urgently considered.

7. System oversight and partnership working at Place level

Better integration between all elements of health and social care across a local area requires there to be a body with knowledge of the whole system at Place level in order to represent the health system in liaison with other services such as housing, criminal justice etc. In addition, engagement with local voluntary and community services requires this fine grained and extensive understanding of the local place landscape. It is important that there is an obvious point of contact. There is a danger that the disruption associated with current changes will result in loss of the current ability to liaise with local providers of public services at the moment when it is most needed. Of course, NHS participation in such local partnerships must be adequately governed so that the NHS can be held accountable for decisions it makes when dealing with other public services. To achieve this, it must be clear which NHS body is accountable, for what and to whom.

The new system

The draft White Paper implies (but does not state) that many of these day to day operational and planning functions will be delegated to local place based committees or provider collaboratives of some kind. The form, role, responsibilities, accountability and governance of these are not currently specified.

Our research suggests that there is a number of major concerns with this:

- Whilst it is understandable that DHSC might be reluctant to pre-specify the form of local place-based structures at this time, this creates a problematic vacuum which risks causing significant disruption and may even jeopardise the continuity of service provision locally.
- This vacuum means that skilled and experienced CCG managers will leave the NHS or seek roles at ICS level. Our study of the impact of the Health and Social Care Act 2012 (Checkland et al., 2018), and of Primary Care Commissioning (McDermott et al., 2018) both demonstrated that such vacuums are problematic, with knowledge, skills and expertise which cannot easily be replaced lost to the NHS.
- In addition, some of the unspecified and informal facilitative roles undertaken by CCGs will be lost. Given that these are usually locally specific, sometimes impossible to measure or specify, and often invisible to those at higher levels of management, it is possible that their loss could generate unanticipated service disruptions.
- Whilst it may be that some of these functions can, in the future, be exercised by place-based collaboratives of some kind, the history of the NHS suggests that, notwithstanding the benefits of collaboration and joint working, there needs to be a body at Place level with the power to intervene or to make decisions if agreement cannot be reached. Whilst providers can and often do work together effectively, their goals and responsibilities differ, and what is right for one type of service may be detrimental to another, and to patients and population health. It is thus not possible for all interests to be completely reconciled at all times, and some sort of brokerage role is essential. This function requires detailed local knowledge and independence from individual providers, and therefore cannot be fulfilled by a collaborative body nor by a distant ICS. Importantly, it cannot be assumed that local 'Places' can safely decide for themselves who should take on this role, nor is it likely that a lead provider can safely take on the role, as they will have important conflicts of interest. As we discussed above, historically there has always been a need for independent oversight which avoids dominance buy a single strong provider. Whilst outcome-based targets and incentives may be important in governing provider behaviour, a local 'lead provider' must be held to account *in real time* for decisions made – retrospective judgement based on outcomes achieved will occur far too late, when irrevocable changes in local services or failures to deliver adequate quality or volumes of care may already have taken place. Conflicts of interest for providers also acting as commissioners of care are real, and transparency or other such mechanisms do not obviate the risks of self dealing (Moran et al, 2017).
- Whilst it is possible that the large organisations across a local Place may agree that a 'lead provider' should take on such an oversight role there is a significant danger that this will disadvantage smaller providers, whose voices may well not be easily heard. Primary Care Networks, for example, do not yet straightforwardly represent the voice of all general practices, and it is possible that, even if PCN leads agree this may not represent the views of their members.
- Past experience of initial under-specification of governance processes in the NHS (specifically the establishment of CCGs in 2013, see Checkland et al, 2013) demonstrates that it will be necessary for NHSE to ensure sufficiently robust constitutions are adopted by place based committees.
- More generally, the failure to specify what functions must be carried out at Place level and the principles by which decisions should be made means that there will be delay, loss of experienced staff and potential dysfunction if local areas cannot agree on what local arrangements should be.

5. Conclusions

History and our own research suggests that proper governance and accountability as well as the efficient management and oversight of the NHS requires some separation between responsibility for planning services and their provision, with an important role for a 'ring holder' with the power and authority to make decisions about the optimum distribution of resources. Whilst much can be achieved via collaboration of providers within a system, power imbalances, individual provider responsibilities, conflicts of interest and the need for good governance over the expenditure of public money require that there is an independent voice in the system with no vested interests. Whilst much of the time collaborating providers will be able to agree priorities for investment, independent local oversight is necessary. This cannot be discharged via retrospective judgement of outcomes, because such outcomes will always come too late when irrevocable changes have occurred. It is vitally important that such questions are addressed now.

At ICS level, this means that urgent guidance is required as to: the principles by which decision making will occur in ICS statutory bodies; the governance and accountability structures required; and the mechanisms which will be put in place to avoid conflicts of interest and ensure that decisions are made in the interests of the local population.

At Place level, if the exact make up of local provider collaborations is to be a matter for local 'Places' to decide for themselves, the shape of the governance and accountability framework at this level, the principles by which decisions are made, and the establishment of a local 'ring holder' to oversee Place-level functions must be rapidly made clear, in order to avoid Places making decisions about structures which need to be undone in the future. We believe that this could be addressed by making it clear now that, where ICSs decide that they need Place-based structures to discharge their responsibilities, there will be a statutory Place committee of the ICS which carries delegated responsibility for planning and which discharges or delegates commissioning functions locally. Importantly this role cannot, for reasons of good governance and to avoid conflicts of interest, be taken by a local lead provider. Research into alliance contracting shows that, whilst such contracts can support the development of partnership working, they tend to be characterised by avoidance of hard decisions which might disadvantage one of the parties (Sanderson et al, 2018). An independent body is required that can be seen as an honest broker and which can ensure that such decisions are made in the best interests of the local population. Principles by which membership of this committee will be determined, along with accountabilities and the processes by which decisions will be made need to be set out urgently. History shows that, whilst the configuration of local partnerships can be locally determined, governance structures and the principles governing decision making cannot.

Whilst providers may be represented on an advisory committee at Place level, and the Place commissioning committee may be allowed to form joint committees with providers or delegate functions to a lead provider, statutory responsibility and accountability must sit with a Place-based committee which is independent and free from conflicts of interest.

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