Inspiring change

What we should ask for in NHS legislation

Toby Lambert & Tom Kibasi

June 2018

For many months, a new funding settlement for the NHS was known to be on the horizon, and likely to land at between 3 and 4 per cent. The Prime Minister's announcement that legislative reform is back on the table came as more of a surprise, not least because of the precarious position in parliament. It was deftly positioned as legislation originating from the health service itself: a clever tactic to make it harder for the Labour Party to oppose it. But whatever the political shenanigans, there is clearly an opportunity to be grasped for the health service to shape its future. Rather than debate the money, we should seize the initiative.

And why now? We all know the Parliamentary arithmetic is awful and the government is distracted by Brexit. It is precisely this that gives us the opportunity – just as we have managed to end austerity for the NHS, a proposal developed as the ask for the NHS will be difficult to resist and can be positioned as the government having an agenda besides Brexit.

So what should we ask for? We know that our greatest success, and challenge, is an ageing population with the burden of disease that brings. We have a clear response and a shared vision to integrate services around patients. Time and again we find that the rules and structures embodied in the Lansley reforms and the 2012 Act get in the way of what we want to achieve. So here are five changes to legislation, as a 'starter for ten', that will support the service to integrate care.

First, we need the ability to create 'Integrated Care Trusts'. If we all believe the future is integrating services around patients, then bringing all those services together under one roof will facilitate this. Integrated care trusts could bring together out of hours services, extended primary care services, community mental health and learning disabilities, community outreach services, some outpatient services, diagnostics and so on. In theory, CCGs can commission integrated services, through multi-speciality community providers contracts, today. But barely any providers currently deliver all these services, and many are struggling to work out how to respond – joint ventures, alliances, prime provider models are possible but highly complicated. Legislatively this is easy – give Secretary of State the power to create NHS trusts again, and the power to direct the transfer of services from other NHS bodies to the integrated care trusts.

Second, we should bring all commissioning under one roof. The 2012 Act gave commissioning of specialist services and primary care to NHS England, a lot of public health to local authorities and the rest to CCGs. That can't be good for integrating care. Since 2012, much primary care commissioning has been devolved to CCGs, though legislation requires it be overseen by a discrete committee and can't be pooled between CCGs. While health promotion should rightly stay with local authorities, commissioning of services such as sexual health should come back; much care currently designated as specialist could be commissioned locally. Where scale does make sense, this could be facilitated regionally. Again, it can be done now – devolution in Manchester shows the way. But it could be so much easier.

Following on from this, third, we should enable STPs to take on commissioning functions. Many parts of the country are already creating what is in effect an STP tier, with shared accountable officers, shared management teams, shared support functions and strategic commissioning. But again, it's done as a work around with complex governance arrangements, delegated decision making and no statutory underpinning. Why not make these the commissioners of services?

Fourth, it is time to recreate a proper regional tier. We call them Health and Care Authorities, you might think of other names! NHS England and NHS Improvement are already attempting to form a unified regional tier shows the need and shows it can be done. Virtually every other health system in the world has one. The gain is creating a regional tier that can set, coordinate

and oversee regional health strategies, reconcile these conflicting demands, give a unified message – and space – the local NHS to get on with transforming and integrating services.

Fifth, we need to simplify the top of the system. We need a single NHS Headquarters, bringing together NHS England, NHS Improvement, Health Education England and the service delivery functions of Public Health England (CQC and NICE should remain independent). And we need to simplify some key processes: for example, consulting on and voting on a national tariff every year sounded like a nice idea, but has been a mess. If we want to get on with developing new ways of paying for care that support integrated care, sweep away the consultation periods and publication requirements and allow payment to focus on improving tariff.

Five proposed changes. Individually sensible, collectively coherent, much simpler, and together providing the time, space and ability for the service to make the changes we all want to see more swiftly.

The authors

Toby Lambert
Manager at CF and former director of strategy at Monitor

Tom Kibasi
Director of IPPR

CF
91 Wimpole Street
London
W1G 0EF
www.carnallfarrar.com

IPPR
14 Buckingham Street
London
WC2N 6DF
www.ippr.org