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Will a new NHS structure in England help recovery from the pandemic?

The health policy challenges facing the NHS and government are enormous, but **Hugh Alderwick and colleagues** argue that a major reorganisation is not the solution

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The NHS has just faced the most difficult year in its history. The arrival of covid-19 vaccines provides hope that the UK may bring the pandemic under control in 2021, but the NHS will feel the effects of covid-19 for many years. Serious short term challenges also remain: hospitals are under extreme strain,¹ the backlog of unmet healthcare needs is substantial,² and the NHS faces the mammoth task of vaccinating the population against covid-19.³

Amid these challenges, NHS leaders are calling for changes to NHS structures and legislation. In November 2020, NHS England published proposals for new legislation to change the way the NHS is organised.⁴ The changes are designed to support local NHS organisations to collaborate to improve care and manage resources as they recover from covid-19. We draw on evidence from the long history of NHS reorganisations to assess the proposals and help understand their potential effect, and outline key questions for the NHS and government as they develop the plans further.

Policy context

Before covid-19, the national strategy guiding the development of the NHS in England was the long term plan.⁵ The plan—published in 2019—focused on developing more integrated services within the NHS and between health and social care, boosting disease prevention, and improving cancer, mental health, and other services.⁶ A mix of policy mechanisms was proposed to drive progress, including new contracts for general practitioners, revised quality measurement, and greater use of digital technology. The logic was that collaboration between local agencies would improve services, contributing to better population health.

But the rules governing the NHS in England were not designed with this logic in mind. The Health and Social Care Act 2012 sought to strengthen competition within the healthcare system and created a complex and fragmented organisational structure. The aim of integrating services was supposed to be balanced with competition among providers.⁷ NHS England has since established sustainability and transformation partnerships and integrated care systems (ICSs)—partnerships of NHS commissioners, providers, and local government in 42 areas of England—to join up local services. But these partnerships have no formal powers and must navigate the 2012 act's rules on competition.

As a result, NHS England proposed new legislation to government in 2019.⁸ The idea was to bring the rules governing the NHS closer in line with the direction the system was heading in practice.

Proposals included removing requirements to competitively tender some NHS services, and establishing local partnership committees with powers to make decisions on local priorities and spending. The proposals were designed to avoid a major reorganisation but risked replacing one set of workarounds with another.⁹ The plans were shelved when covid-19 hit, but now legislation is back on the agenda¹⁰ and NHS England has published expanded proposals for changes to the NHS after the pandemic.

Proposed NHS structure

The proposals⁴ include a mix of aspirations, organisational changes, and policy and legislative fixes. A new NHS structure is outlined with four layers of NHS agencies and partnerships ([box 1](#)).

Box 1: Summary of proposals for new health system structure in England

- NHS organisations will work with local authorities and others to organise and deliver health and social care services in “places”—defined by existing local authority boundaries. Joint decision making arrangements should be developed between local agencies, which may be given responsibility to manage budgets for services. NHS organisations will be expected to collaborate with non-medical services to meet the social, economic, and wider health needs of the population.
- All NHS providers will need to join a provider collaborative. These may be vertical—including primary, community, mental health, and acute hospital services within a place—or horizontal—which might include multiple hospitals providing specialist services across larger areas. NHS England also calls for legislative changes to allow NHS integrated care providers to be established that can hold single contracts for all NHS services in an area.
- Collaborations between NHS providers, commissioners, and local authorities in 42 geographical areas (covering populations of one to three million). ICSs will become a new intermediate tier of the health system and control a “single pot” of NHS resources.
- NHS England outlines two options for enshrining ICSs in legislation. The first is that ICSs are established as joint committees made up of existing organisations, with mechanisms to make collective decisions. Clinical commissioning groups (CCGs) would merge to fit ICS boundaries. The second—NHS England's preferred option—is that ICSs are created as new NHS bodies with a duty to “secure the effective provision of health services to meet the needs of the system population.” Each ICS would have a chief executive and a board that would include NHS providers and local authorities. CCGs would be abolished, and their functions taken on by the ICS.

- National NHS bodies will shift their focus to regulating and overseeing these new systems of care. Legislation would be needed to formally merge NHS England and NHS Improvement, to provide a “single, clear voice” to local NHS organisations. ICSs would take on some of the functions of the regional arms of NHS England and Improvement.

The centrepiece of the new NHS structure is integrated care systems (ICSs): 42 area based partnerships between the NHS and local government that currently exist informally (some areas are not yet ICSs¹¹) but under NHS England’s preferred plans would be established in legislation as new NHS agencies, responsible for controlling most healthcare resources and leading service changes. A further tier of organisational partnerships between the NHS and local government—so called “places,” based on local authority areas—and compulsory NHS provider collaborations would join ICSs in a new NHS landscape founded on collaboration rather than competition. NHS England wants these changes implemented by 2022.

Analysis of the proposals

The proposals for a new NHS structure lack detail, so it is not possible to fully assess their likely effect. But several key issues can be identified from the proposals so far.

Benefits of integration risk being overstated

Overall, the emphasis on closer collaboration between the NHS, local government, and other agencies makes sense—and goes with the grain of recent national policy initiatives. But the potential benefits of integrated care—efforts to coordinate services within the healthcare system, or between health and social care—have long been overestimated by policy makers. Evidence suggests that integrated care may improve patient satisfaction, access to services, and perceived quality of care, but evidence of effect on resource use and health outcomes is limited—and potential benefits may be modest and take time to be realised.^{12–14} Despite the clear logic behind greater cross-sector collaboration to improve population health,^{15–16} there is limited evidence to suggest that partnerships between local healthcare and non-healthcare agencies improve population health.^{17–19}

This doesn’t mean that collaboration is bad or ill advised. But the risk is that NHS leaders’ faith in collaboration outpaces its ability to deliver. Making collaboration work also depends as much on culture, management, resources, and other factors as it does on NHS rules and structures.^{20–22} Formal duties to collaborate or mergers of NHS functions do not necessarily produce collaboration in practice.

Area health authorities are back—but how will they work?

Establishing a new regional tier of the NHS in England—ICSs—could improve the murky accountabilities in today’s health system. NHS leaders have a long history of reinventing the “intermediate” tier of the health service²³—and most national public health care systems have some form of regional management layer. But the 2012 act opted to remove it, leaving a vacuum in strategic and operational oversight of the NHS in England. In this context, the redevelopment of the regional tier through ICSs fits with the historical development of the NHS. ICSs bear some resemblance to the area health

authorities created through NHS reforms in 1974²⁴ and strategic health authorities established in the early 2000s.²⁵ But creating organisations is easier on paper than in practice: experience shows that merging and creating new agencies can cause major disruption.²⁶

Limited detail is provided on how ICSs will work and interact with other parts of the health system. For example, NHS providers are to sit on ICS boards. But how much power will the ICS have over its constituent providers? How will ICSs hold new provider collaboratives to account? And how will NHS providers balance their duty to collaborate with existing responsibilities as individual organisations—particularly foundation trusts, which are technically autonomous agencies with distinct local accountabilities? The role of regulation in overseeing local systems is not clearly set out. There is a risk that unifying NHS and other agencies affects patient choice and responsiveness.

With clinical commissioning groups abolished—or at least merged across larger areas—it is unclear how the “place” level of the new NHS will be organised. The proposals suggest primary care networks—groups of general practices that collaborate to deliver defined services for populations of around 30 000–50 000²⁷—will play a central role. But these networks are nascent and small scale,²⁸ and redefining their functions risks derailing early progress.

The role of local government—which is responsible for social care, some public health functions, and other social services—in the new NHS collaborations is, so far, poorly defined. This is a major weakness given that local authorities have a central role in tackling social, economic, and environmental determinants of health. Local authorities have often not been treated as equal partners by NHS leaders.²⁹ Meaningful involvement of local authorities in any new arrangements will be essential.

Commissioning is dead: long live commissioning?

Formally establishing ICSs and mandating provider collaboration would further diminish—if not dissolve—the NHS internal market. The 2012 act’s version of commissioning would be all but dead: CCGs gone or hollowed out, and compulsory competitive tendering abolished. Changes to simplify procurement rules and make joint purchasing decisions easier should help reduce fragmentation and complexity in the current system.³⁰ But commissioning would live on. ICSs would be responsible for “strategic commissioning”—including assessing health needs, planning services, and allocating funds to improve local health and healthcare. New payment models would be developed to help do this.³¹

Changes to commissioning in the NHS are nothing new. Commissioners have existed in an almost constant state of flux since the birth of the purchaser-provider split in 1991 (table 1). Assessing the contribution of commissioning to improvement in the NHS is challenging—and regular reorganisations make it even harder. But, overall, evidence suggests that NHS commissioning in and of itself has consistently failed to have a significant impact on patient care or outcomes.^{32–35} Indeed, strategic purchasing has failed to live up to policy makers’ expectations in several countries—hampered by asymmetries in information, political and market power, and resources.³⁶

Era	Main changes to NHS commissioning	Rationale for change
<i>Early 1990s: creation of internal market</i>	Separation of the purchaser and provider functions in the NHS, creating two models of commissioning. (1) Health authority purchasers were created to buy acute or community healthcare services on behalf of local populations. Health authorities were also responsible for assessing population health needs and held public health responsibilities. Following their creation, there were several mergers and boundary changes. New functions, including for primary care contracting, transferred to health authorities in the mid-1990s	Funding would not automatically flow from purchaser to provider, and so providers would have to compete for business. Competition would encourage providers to be more efficient, responsive, and increase quality of care
	(2) GP fundholding: practices were given the option of holding budgets to cover the cost of a range of (mainly elective) services and were able to keep any savings from their budget. Some fundholders came together in networks to create organisations that could pool resources. Non-fundholding GPs started working together in GP commissioning groups. GP fundholding was extended in 1995-96 with the creation of total purchasing pilots	Fundholding would enable GPs to offer patients an alternative purchaser of hospital care, give GPs a financial incentive to manage costs, and assumed that GPs would have more ability to lever change than health authorities (because of knowledge of services and hospitals being more responsive to GPs)
<i>1997-2010: New Labour's market reforms</i>	The purchaser-provider split was retained. GP fundholding was abolished and health authorities lost their purchasing role except for highly specialised services. Primary care groups were created and made responsible for purchasing hospital, community, and primary care services. Cooperation not competition was emphasised, and a new performance framework introduced. By 2002, primary care groups had been replaced by primary care trusts (PCTs), which brought together the functions of health authorities and primary care groups. PCTs also took on responsibility for managing community and other services, and worked with partners—including local authorities and other PCTs—to plan and purchase other services	Scrapping GP fundholding would reduce management and administrative costs. Strong local commissioners would be able to assume financial risk for a defined population
	In 2008-09, PCTs were asked to separate their internal commissioner and provider functions	PCT separation would mean more robust purchaser challenge and improve services. PCTs could focus on commissioning activities so commissioning would be enhanced
	Practice based commissioning (PBC)—a voluntary form of primary care led purchasing—was introduced in 2005. PCTs could delegate a notional budget to a practice or group of practices to plan and commission a set of community and hospital services for their enrolled population	Practice based commissioning aimed to give those working in primary care more power over commissioning, based on the idea that they are best placed to make decisions about their patients' needs
<i>2010-15: Coalition government reforms</i>	PCTs were abolished. GP led clinical commissioning groups (CCGs) were created, responsible for planning and commissioning the majority of health services for their local area. Many CCGs have merged since they were first created. An independent NHS Commissioning Board (later renamed NHS England) was created and retained some responsibility for commissioning primary care and specialised services. NHS England has since devolved more responsibility to CCGs and reduced its role in direct commissioning. Local health and wellbeing boards were established to link GP commissioners and local authorities, and to provide a forum for commissioning plans to be brought together	Sought to build on the policies of previous governments to put the structures needed to embed a provider market in the NHS into legislation. Aimed to extend competition and choice within the NHS, and increase clinical engagement in commissioning

Past reorganisations have di yǔ 𠂇 鼓di yǔ 去 萑厉4 伽火𠂇 介 盞 x 錦隕 八闌 黜鱗韃駢臙匿 官廿韃彖 盞 x 隕 八闌一鮎

NHS England states—perhaps pre-emptively—that it does not want to trigger a “distracting top-down reorganisation” of the NHS. But it is hard to see how their proposals to abolish CCGs and create ICSs would avoid this. There is also a risk government will use the opportunity of new NHS legislation to introduce more widespread changes. This is hinted at by NHS England, which “envisage[s] Parliament using the legislation to specify the Secretary of State’s legal powers of direction in respect of NHS England.” Changes to bring the NHS under closer ministerial control are likely to be rooted in short term political interests, not clear thinking about the right balance of national responsibilities.

Health policy priorities after the pandemic

The NHS needs an updated strategy when it finally emerges from the pandemic. NHS England’s proposals for new legislation are based on delivering the NHS long term plan. But the plan was produced before the pandemic and its implementation has been blown off course.⁴⁴ Policy and system changes in the NHS during 2020 have also been substantial.⁴⁵

The scale of the challenges facing the NHS after covid-19 are staggering—including addressing chronic staff shortages,⁴⁶ prioritising the backlog of unmet healthcare needs,² and working with other services to tackle wide health inequalities exacerbated by covid-19.⁴⁷ Resources to do this are constrained.⁴⁸

Public policy challenges facing government are even bigger. Delivering the prime minister’s pledge to “level up” the country requires cross-government intervention to reduce health inequalities.⁴⁹ Adult social care in England is in desperate need of reform after decades of neglect.⁴⁹ Action is needed to reverse increases in child poverty and destitution.^{50 51} The list goes on.

In this context, the onus is on NHS leaders to articulate how changes to NHS structures fit within a new guiding strategy for the future of the health and care system. The ambition to close the gap between the “rules in form” and the “rules in use”¹⁰ in today’s NHS makes sense—and the need for legal changes to reduce fragmentation and complexity has long been recognised.⁵² But any changes to legislation should be targeted and backed by clear evidence or logic. This may mean initially pursuing limited fixes to amend competition rules and strengthen the power of ICSs that can evolve over time—not “big bang” changes that could damage or distract. A major structural reorganisation of the healthcare system would not be the answer to the problems facing the NHS and its patients after the pandemic.

Key messages

- NHS leaders in England are calling for changes to healthcare system structures and legislation
- The changes are designed to support collaboration between organisations and services, and could mean some NHS agencies being abolished and new area based authorities created
- Encouraging collaboration makes sense, but the potential benefits of the new system proposed may be overstated and the risks of reorganisation underplayed
- NHS leaders and government have a long list of policy priorities as the country recovers from the pandemic and a major structural reorganisation of the healthcare system should not be one of them

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