Introduction

Following DAC Beachcroft's work to more clearly define the requirements of the NHS Five Year Forward View, which includes our research and report 'Understanding the Barriers to Innovation' and also our recent examination of the strategic challenges in 'The Route to Integrated Healthcare', we have established this advice manual to guide senior leaders through the challenging landscape of health and social care integration.

This set of advice sheets examines the strategic, operational, regulatory and risk issues associated with the integration of services, for example, issues relating to workforce, regulatory burdens and choice of organisational structures (to name a few). Each sheet includes the latest advice and practical examples of how to overcome any associated barriers.

The story so far

Achieving the objectives set out in the NHS Five Year Forward View (5YFV) is a significant challenge, and the pace of change appears tentative so far. In fact, it is now generally accepted that the vision of the 5YFV is more likely to be delivered in 10 to 15 years to make the change successful and sustainable.

The Multispecialty Community Providers (MCPs) and primary and acute care systems (PACS) frameworks illustrate some of the contracting structures emerging from the 14 Vanguards. It is clear that there is still a way to go before real structural change and new contracting models are widely adopted, particularly given the challenges around the recoverability of VAT for NHS bodies when sub-contracting from corporate joint ventures. The collapse of the Uniting Care Partnership contract in Cambridgeshire has highlighted the enormous challenge and complexity of moving financial risks around the system, particularly where the underlying data to support assumptions around those risks is not fully developed. It is understandable that many emerging MCP and PACS systems are avoiding the 'big bang' approach in favour of a more measured and stepped approach to collaboration and integration. NHS England, NHS Improvement and the Care Quality Commission are currently working on a joint assurance process, with checkpoints to assure that where there are 'big bang' transactions in the future, there is a joined-up level of scrutiny and due diligence applied to the process and underlying assumptions.

So far, not much has changed in the wake of a vote for Brexit. Any potential changes to the legal framework following exit from the EU are not yet known and so some of the challenges of EU law, for example around the application of EU procurement law to new models of care, remain to be navigated. On the up-side, greater clarity in the Public Contract Regulations 2015 on the ability of public bodies to collaborate and to establish shared services is welcome, particularly in light of the Carter Report and the drive for greater efficiencies as well as collaboration between provider organisations. This creates clear opportunities for better efficiency planning particularly across Sustainability and Transformation Plan (STP) footprints. More recently, the Wachter Review has provided the sector with an assessment of the digitisation of secondary care and issued recommendations on the way forward. This was a well-timed report that followed the announcement of £4.2 billion of funding to support this digitisation and a general consensus that technology is to play a significant role in paving the way forward for the NHS.

The more efficient use of NHS estates both for clinical use and in wider collaboration with other public sector and housing providers remains high on the agenda, with CCGs and providers looking at options for better utilisation and management of the estate. There is a clear link to the technology strategy and developing a more efficient use of the workforce within and across sectors.

Alongside this, the NHS workforce has also seen a lot of emphasis and is an area that faces some of the most complex issues; ranging from strategic change to financial challenges and greater regulatory scrutiny. There have been numerous announcements on the health and social care workforce throughout the year which, as an area with immense capacity to create the efficiency changes needed, is no surprise.

Heading in the right direction

As one of the market leaders in the provision of legal advice to the health and social care sector, our legal experts at DAC Beachcroft have created this manual for senior leaders in the health sector.

Each advice sheet looks at one of a series of identified issues; setting out the significance of each area, the key challenges faced within it and next steps, or practical guidance, in overcoming these issues and progressing health and social care integration.

Commissioning integration

STRATEGIC / OPERATIONAL / REGULATORY / RISK

DAC Beachcroft Partner Anne Crofts advises commissioners and providers on commissioning integration and the new regulatory landscape.

Why this area is important

Integrating care so that services are designed around patient needs rather than around institutions or organisations is a key plank of government health reforms. The aim is to drive up quality and improve efficiency.

The government has not prescribed models for integrated care. It wants innovation and local iterations that best fit local needs; however, there has been no substantive change to primary legislation to facilitate this, so commissioners must use the legal tools currently available to them.

Key issues

While local authority budgets have been slashed, health budgets have had more protection. If no ring-fencing is put in place some observers worry that NHS money could be spent on other council activities.

Commissioners in the NHS or local authorities can use Section 75 of the NHS Act 2006 to pool funds and delegate the exercise of functions when working out a local approach to achieving integration. The onus remains on organisations on the ground to make this happen.

But the 2012 Health and Social Care Act cemented the split between commissioners and providers, and bars providers from taking on certain commissioner functions. Some perceive this as a barrier to achieving 'the Holy Grail of integration' – the development of standalone ACOs that carry out both commissioning and provision of services. The idea is that they will hold a capitated budget for the provision of services to a population and bring together primary and secondary care, mental health and social care. CCGs cannot currently delegate their commissioning functions to an ACO, although it could in principle be possible for an ACO to manage some of the CCG's functions.

Potential solutions

While new legislation to address such concerns about ACOs is unlikely any time soon, NHS and social care leaders want more political support so they can forge ahead in forming new collaborations without fear of legal challenge.

It is not clear, in the wake of Brexit, whether NHS adherence to the European framework of laws on commissioning and procurement will change. Either way, there is domestic legislation which requires CCGs and NHS England to consider and test the market for the most capable providers.

In the meantime, the England-wide network of 44 Sustainability and Transformation Plans (STPs) are intended to bring all significant players together within health and care systems to give shape to local integration. These plans will need to steer a course through the existing procurement and competition regime seeking to encourage local organisations to work more closely together while at the same time ensuring new contract opportunities are opened up to existing markets.

More information

For advice on commissioning integration issues, contact Anne Crofts on +44 (0)20 7894 6531 or acrofts@dacbeachcroft.com.

AT A GLANCE

- Consult with all interested parties, get everyone in the same place, establish what you want to achieve and ensure you get the governance right
- Section 75 agreements (now widened to allow pooling of money for primary medical care provision) still underpin joint and collaborative working with Local Authorities, while devolution powers can facilitate collaboration on a wider scale
- Accountable Care Organisations (ACOs), partnerships and systems must not cross the line between provider and commissioner functions; the legislation does not permit commissioner functions to be delegated from commissioners to providers

Public consultation and engagement

STRATEGIC / OPERATIONAL / REGULATORY / RISK

DAC Beachcroft Partner Ros Ashcroft outlines the importance of public consultation when setting out plans to integrate health and social care.

Why this area is important

Consultation and engagement is a legal requirement where changes in models of care, service re-configuration or re-provision are being planned. There are specific statutory requirements on both NHS providers and NHS commissioners as to consultation and engagement with the public, in sections 13Q, 14Z2 and 242 of the National Health Service Act 2006 ("2006 Act"). Section 244 of the 2006 Act and the Regulations under it require consultation with local authorities about proposed changes to health services in their area. In addition, consultation is essential to enable health bodies to demonstrate compliance with their duties under the Equality Act 2010, and other general duties imposed on CCGs and NHS England by the 2006 Act.

Ignoring the need for consultation and engagement, or delaying or short-circuiting the process of consultation, will greatly increase the potential for legal challenge to proposed service changes. There can be no doubt as to the appetite for such challenges where there are strong objections to proposals.

The recent 'Healthier Together' judicial review challenge (to the proposed closure of an A&E department as part of a wider integration project within Greater Manchester) is just the most recent example. If such challenges succeed, they will significantly disrupt planned changes and delay the improvements and cost savings they sought to achieve. Even where a challenge does not succeed, as in the case of Healthier Together, the process is costly in terms of management time and disruption to timetables, and may fracture local relationships and reduce potential savings.

Where it can be demonstrated that proposals have been presented in a timely, transparent and inclusive way and that stakeholders' views have informed the process, people are far more likely to buy-in to the proposals and any challenge is much less likely to succeed.

Key issues

Consultation and engagement are about explaining the aims behind proposed changes and setting out how it will work in practice. It provides a chance to test out the logic of the proposals and their impact on local people.

As such, it can be a positive tool for commissioners and providers to explain why the changes are considered necessary and to emphasise their aim of improving care and maintaining effective local services. The process of preparing for consultation provides an opportunity for the NHS body to analyse and self-challenge the robustness of their proposals. With an increasing focus on outcomes measures on service delivery, consultation also provides a valuable chance to identify appropriate measures, explore how outcomes can be identified and prepare the public for the need to capture and report on particular data.

Health bodies can be nervous about engagement with the public. It has to be acknowledged that the public can react badly to proposed changes, particularly where this involves a closure of an existing facility. However, it is essential to engage with the public at a formative stage and to be honest about the drivers for change. For example, that changes are necessary to save money and not just about improving care. It is unwise to gloss over elements of a plan for fear that they might generate a negative public reaction, or to delay consultation until it is more difficult to change direction. If the public are concerned about a proposal they will be particularly alert to any lack of clarity about its purposes or any indication that the decision has effectively already been taken.

Even if some form of challenge is inevitable, it is essential to use consultation to reduce the legal points available to challengers and to support rather than detract from the substantive case for change.

Potential solutions

Don't think of consultation as a one-size-fits-all concept, which can only mean a single, comprehensive public consultation document. Consultation and engagement can take a wide range of forms. Depending on the nature and scope of your proposals, a series of different engagements may actually be more appropriate than one large consultation. Plan an engagement programme that reflects the make-up of your stakeholder groups to generate useful information at relevant points in your planning process.

Early engagement on specific issues can provide new information about a demographic: what the population is and where its needs and priorities lie, or likely concerns about a proposal. This can be used to make later consultation activities more effective in explaining proposals and reassuring the public about their purpose and impact.

Engaging with patients and the wider public is crucial, but they are not the only stakeholders to consider. Clinicians are a key group whose views have a huge influence on the public and on the courts, and have shown themselves to be prepared to challenge organisational decisions (the Healthier Together judicial review was initiated by clinicians). Early engagement with staff can forestall significant issues later, both internally and with other stakeholders.

Similarly, do not forget to involve local authorities at the right time. In one recent case, the legal challenge to a service change by an NHS Trust was brought by the local authority itself, which believed it had not been appropriately consulted and given the opportunity to carry out its review and scrutiny functions. The judicial review proceedings were settled and withdrawn, but this took time and expense and had the potential to affect the public's view of the plans.

Use local media wisely. In London, bodies involved in an integration project have used local radio and newspapers to disseminate information about plans to share patient data.

AT A GLANCE

- Consultation and engagement is a legal requirement and an essential tool to planning integration, where proposals will have an impact on the way services are delivered or on the range of services available
- Consultation must start at an early stage and involve the whole spectrum of service users and other stakeholders
- Honesty and transparency about the drivers for proposals and their likely impact is vital, and can result in consultation being a positive tool for all involved

More information

For advice on public consultation issues, contact Ros Ashcroft on +44 (0)117 918 2387 or rashcroft@dacbeachcroft.com.

Devolution

STRATEGIC / OPERATIONAL / REGULATORY / RISK

DAC Beachcroft Partner Ros Ashcroft advises NHS commissioners and local authorities on the legal issues associated with devolution of health and social care functions, as commissioning bodies look to develop more integrated and efficient health and social care services.

Why this area is important

The Cities and Local Government Devolution Act allows the transfer of statutory functions, like health commissioning, to local and combined authorities from other public bodies. It also allows for the powers of other public bodies to be shared and exercised jointly with local and combined authorities.

The Act could be applied widely to any public functions, and could be a powerful tool to achieve integration of health and social care services. It reflects the increasing focus on place-based approaches to public service delivery, which allow services to be shaped to the needs of the local population and to harness the resources offered by the local economy.

However, the Act works only in one direction, transferring or sharing functions from other organisations and giving them to local government – it does not permit transfers in the other direction. So the Act could allow local or combined authorities to drive the development of fully integrated health and social care services, because they would be able to exercise all the relevant commissioning functions. But a wholesale, one-way shift of control of this kind would be very different to what many people envisage when they talk about integration of health and social care, i.e. all parties sharing functions and working together in a flexible way.

Key issues

We are seeing almost parallel developments at present; within the health sector you have the NHS Five Year Forward View (5YFV) and the push to create new models for delivering healthcare, including Multispecialty Community Providers (MCPs) and Accountable Care Organisations (ACOs). From a local authority perspective, the Act could shift commissioning and management of health and social care to local authorities on a place-based basis. It is difficult to see how these two developments would come together in one place: whether a local authority which has just been given new powers over health services would want to cede control to an MCP or ACO is a moot point.

In addition, the requirement within the health service to develop and implement Sustainability and Transformation Plans (STPs) means development of a health-specific concept of place, or local health economy. That may not always match up with the area served by a single local authority which would be the focus of any devolution of health powers under the Act. For any health and social care devolution proposal to win NHS England's support (which is in practical terms a must), the parties must be able to show how it fits in with the area's STP.

Use of the core transfer powers in the Act requires a statutory instrument (secondary legislation), and is likely to be used only in a small number of cases where a very clear and powerful case for devolution has been made.

On the ground, progress towards true devolution of health powers has been slow. Manchester has been the flagship of devolution, and its plans include health and social care functions. But at present, it is not planning to use the Act's main powers to formally transfer or share NHS powers with local government: rather it has established a governance structure for integrating planning and commissioning of health and social care under existing legal frameworks.

Aside from Manchester and London, which are doing things slightly differently, there are no indications at this stage that other areas are going to be progressing ambitious health and social care devolution plans which go beyond the use of existing legal powers to integrate – particularly under s75 and s13Z of the NHS Act 2006.

However, the Act did also make some important changes to the NHS Act 2006, increasing the scope for NHS England and CCGs to delegate or share functions with each other and with local authorities and establish pooled budgets. These are powers which do not require secondary legislation and can be used on an individual basis. We expect to see much wider take up of these powers as CCGs and local authorities increasingly look to integrate their commissioning functions.

'Devolution' is not essential to make integration happen, and in some senses could be a distraction from progress towards integration on the ground. What we are more likely to see is a series of incremental changes that may well be tagged as 'devolution' but might as easily be termed 'integration', and which use some of the increased delegation powers that the Act has brought to CCGs and NHS England, alongside the powers in s75 of the NHS Act 2006.

Potential solutions

Devolution of health and social care may work in geographically defined areas: where the local authority's area is coterminous with the health economy, so that there is one local or combined authority and a limited number of health providers and CCGs which all identify themselves as serving the same population. The Act creates an opportunity for a truly transformational change in the way in which health and social care is commissioned in an area; Greater Manchester has come closest, but so far decided against using those fundamental legal powers. It remains to be seen whether any other area will seek to do so for health and social care.

The devolution agenda has helped to promote a common understanding of the need to develop health and social care services to meet the needs of an identified local population. Even where formal devolution does not take place in the form of transfer of powers to local government, this may influence and encourage new developments in integration, as long as these can be made to fit with budgetary pressures and other NHS initiatives.

More information

For advice on devolution issues, contact Ros Ashcroft on +44 (0)117 918 2387 or rashcroft@dacbeachcroft.com.

AT A GLANCE

- Devolution legislation works in one way only – passing powers to local government
- Successful devolution requires a geographically defined area in which local/combined authority boundaries are broadly coterminous with the health economy
- Wider delegation powers for health bodies and the focus on place-based commissioning and local efficiencies will influence more organic development of integration arrangements for health and social care
- In practice, any devolution of health and social care functions will need to be consistent with the NHS Sustainability and Transformation Plan (STP) footprint and plan for the devolved area

Contracting and corporate structures

STRATEGIC / OPERATIONAL / REGULATORY / RISK

DAC Beachcroft Partner Hamza Drabu advises commissioners and providers in the NHS and independent sector on the issues and challenges that arise around the integration of health and social care services using contracting and corporate structures.

Why this area is important

Integrating health and social care is like assembling a giant set of three-dimensional jigsaws across the country. Each area should have its own shapes and structures but they should all come together to deliver the national aims of the NHS Five Year Forward View (5YFV).

Agreeing clear parameters in contracts or as part of a corporate vehicle for how providers (and potentially commissioners) will work together can help local health systems to integrate.

Ideally, implementing Accountable Care Systems (ACS) in a local health system would remove some of the divide between commissioning and providing services – as providers would be given a capitated budget to provide and procure the provision of services for a population.

Implementing an ACS will therefore involve a risk transfer from commissioners to providers, so the latter must agree and document where that risk sits and how they will plan to collectively mitigate such risk. Contracting and corporate structures are the tools to help allocate those risks amongst the parties in a fair way.

Key issues

Commissioners will need to define the services they are seeking to commission in order that providers can respond accordingly. Where commissioners are seeking to integrate a range of services, such services may be subject to different regulatory regimes, under different types of contract and with different types of payment profiles. Providers that are seeking to collaborate will need to consider whether they wish to do so using contractual structures (i.e. no new legal entity is created) or whether they wish to set up a new corporate vehicle.

Where contracts are being used there is a spectrum of ways that these can be implemented, from a light touch memorandum of understanding (MoU) arrangement overlaying governance to a more commercial contractual joint venture where risk and reward is shared between parties.

If a new corporate vehicle is to be set up, providers should be clear on the scope and objectives of the vehicle. Examination of matters such as VAT for those within the collaboration, pensions, TUPE, insurance and regulatory obligations (e.g. CQC registration) should also be considered.

'Form follows function' is the rule when devising new models of care. Don't start with the goal of setting up a new corporate entity. Rather think about what you want to achieve and how that will work to deliver those aims.

Potential solutions

Before plunging into contracting and corporate structures, build relationships by setting up governance structures, align ideas and share a vision amongst providers.

Where there is a clear opportunity outlined by commissioners for providers to respond to, consider the options for collaboration and carry out a due diligence assessment on the key areas of risk arising from the same.

Make sure that any corporate structures implemented are easy to engage with, and are not engineered largely for the purposes of overcoming regulatory obstacles.

More information

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AT A GLANCE

- Form follows function. Consider what you wish to achieve and detail your aims and objectives
- Do not underestimate the resource required to set up a new corporate vehicle to provide services
- Commissioners should consider their current arrangements and explore whether it is possible to incentivise providers to integrate services by wrapping a contract around existing individual contracts, in a form of alliance agreement

Procurement and competition

STRATEGIC / OPERATIONAL / REGULATORY / RISK

DAC Beachcroft Associate Mary Mundy advises commissioners and providers on how to overcome procurement and competition challenges they may face on the route to integrated healthcare.

Why this area is important

Providers and commissioners are faced with putting in place whole new models of care within very short time-scales. They must also be aware that a whole range of providers, including other NHS organisations, third sector and private companies may be as well placed as incumbent providers to deliver new models. It is essential to go through the process systematically to avoid potentially time consuming and costly legal challenges.

Key issues

Commissioners must comply with the NHS (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 (the "NHS Regulations"), where objectives include patient experience, outcomes and improved efficiency.

From April 2016, the Public Contracts Regulations 2015, which implement the EU Public Directive, required healthcare services to the value of £589,148 or above to be advertised Europe-wide via OJEU (the Official Journal of the European Union).

The reality is that this might not be practical for certain services especially as commissioners face pressure to support local NHS providers even when there are a range of other providers who could offer the services they are looking at re-modelling.

Awarding contracts without going through a competition process is potentially risky. Going with the status quo means commissioners could face challenges from other providers, both public and private, who could deliver the relevant services. A challenge could end with a court declaring the contract ineffective leading to its cancellation and fines and damages to the challenger, and to the organisation which had its contract cancelled.

Where an incumbent provider, which has serviced a contract for many years and sees it as 'their work', has lost out in such a manner it would be in their interest to mount a challenge as the loss of a contract could have an impact on other areas of its service, or indeed its viability.

Potential solutions

CCGs should carry out market assessments to determine who is out there and not just assume that the current providers on the patch and the incumbent are the only ones to talk to.

Where there is comprehensive market engagement, providers are less likely to raise a challenge as they will have at least had an opportunity to be involved in the process.

The NHS Regulations state that a competitive process need not be done if the services are capable of being delivered by only one provider. Under the new models of care scenario there may be many potential providers in an area, in which case it could be difficult to say there is only one capable provider. There are ways to work within the procurement regime, such as shared services and using the so-called 'Teckal' exemption.

The procurement process should be streamlined so that bidders are not put through unnecessary steps, and contain clear specifications to ensure the right provider is appointed. Do not rely on outdated procurement documentation that could be unsuitable for the new model in mind.

More information

For advice on procurement and competition issues, contact Mary Mundy on +44 (0)113 251 4727 or mmundy@dacbeachcroft.com.

AT A GLANCE

- Adopt a systematic approach to avoid legal challenge
- Do not go with the status quo; carry out a market analysis to identify potential providers
- Open dialogue with all potential providers to reduce the potential for legal challenges
- Take time to decide on the model of care you wish to adopt
- Procurement processes can be simple and streamlined. Don't make providers jump through unnecessary hoops

IT integration

STRATEGIC / OPERATIONAL / REGULATORY / RISK

DAC Beachcroft Legal Director Andrew Rankin discusses issues related to IT systems integration in the NHS, and some of the associated legal aspects in managing risks and challenges.

Why this area is important

The digitisation of healthcare in England remains a varied picture, with different health and social care bodies at different stages of digital maturity. It is, however, generally acknowledged that after years of under investment in information technology in secondary care for example, many NHS provider organisations still have much more to do.

The benefits of having the right information at the right time for clinicians is well understood – both in terms of quality and safety. For example, effective clinical systems will ensure that professionals document handovers accurately, are accountable, and in the context of integration of care around the needs of the patient, will ensure that it is easier to share information across multi-disciplinary teams across different parts of the care pathway. At the same time, systems and data have the potential to deliver operational efficiency savings, better commissioning and greater understanding of the health of populations.

Key issues

Historically, data relating to health of patients was heavily siloed according to organisational structure. That was due in part to sensitivity of the data collected, and concerns, (real or otherwise) about information governance. This approach was also partly due to the sheer complexity and volume of data collected by the NHS. It also reflects the way that systems were often procured in the NHS: system by system. At the same time there has historically, in our view, been a lack of incentives for NHS boards to make significant investment decisions in large-scale IT schemes, particularly in light of some high-profile failures in the field.

The NHS Five Year Forward View (5YFV) made a commitment that by 2020 there would be "fully interoperable electronic health records so that patient records are paperless". In September 2016, the Wachter Review, commissioned by the Department of Health, was intended to provide an assessment of the digitisation of secondary care in hospitals in the UK, and to make recommendations on the way forward. The review follows in the wake of a number of policy and funding announcements, including £4.2 billion funding to support the digitisation of the NHS.

Commentators might be sceptical that the NHS is again returning to the same ground on which there has been past failure – the achievement of integrated electronic health patient records across health and social care. For example, many hospitals in England had, until very recently, made little progress beyond so called 'PAS' (patient administration systems) and PAS Plus replacements alongside departmental systems (and in some cases, portals pulling together information).

Potential solutions

Whilst most organisations are some way off being paperless, many secondary care organisations are progressing, or have plans or ambitions to progress clinically-rich electronic patient record systems across their organisation – the corner stone of any ambition for a hospital to go digital.

We would expect the number of NHS organisations looking at so called population health management tools to grow. These tools aggregate patient data across multiple health technology resources (fully implemented from secondary care, primary care, social care, and mental health and community services) and include that data into a single patient record. Such systems are potentially extremely powerful in contributing to the vision of joined up healthcare. A single patient record allows users to monitor and identify patients with for example, particular chronic conditions across care pathways and at the same time produce analytics to help with population health that can assist in disease prevention.

The procurement exercise used to select a supplier should be used in the right way – to identify and agree key risk allocation points on deals, to flush out issues before they occur, and to gain common understanding.

Increasingly, the market is looking towards framework contracts for the procurement of digital systems that can be utilised by suppliers, providing what should be a swifter route to market for both suppliers and buyers. This brings with it (in effect) centralisation of certain aspects of contract negotiation, and to some extent we suspect consolidation of the market in the longer term. Suppliers are likely to have to find a place on the relevant framework in order to operate credibly in the relevant market. However, if frameworks are used, NHS bodies should not automatically assume there is nothing further to do – complex system integration procurements require a level of engagement between buyer and customer – within the confines of public procurement law.

Often, implementing clinical information systems are in effect significant change projects for the NHS customers who buy such systems: changes in work flow and working practices being required. Organisations need to identify suppliers who are likely to support them when implementing complex systems – if, for example, a hospital is implementing a complex electronic patient record system the process is unlikely to be straightforward. Trusts need to find suppliers who are not looking for ways out of contractual obligations, or continuously seeking changes for which they can charge. Allowing a supplier to believe that this is also a good deal for them (rather than a deal where they have too heavily discounted their pricing) is likely to help in that.

Finally, buying NHS health bodies must plan for the amount of resources that they will need to put forward to deliver successful projects, and not underestimate the time required from front line clinical staff.

Once the deal is done, and implementation of the project is complete, it must be recognised that going live with a system is the beginning and not the end of implementation of health information technology.

AT A GLANCE

- Historically, data relating to health of patients was heavily 'siloed' according to organisational structure
- The NHS has in the past lagged behind other parts of the economy in terms of investment in systems and data
- However, the move towards a paperless, or paper 'lite', NHS continues
- The complexities of completing a procurement with a supplier for a major clinical or administration system should not be underestimated, nor the levels of dependency in terms of what buying organisations must do during implementation
- Implementation is only the beginning

More information

For advice on IT integration and technology issues, contact Andrew Rankin on +44 (0)161 934 3220 or arankin@dacbeachcroft.com.

Estates and facilities

STRATEGIC / OPERATIONAL / REGULATORY / RISK

DAC Beachcroft Partner Anne Batanero and Associate Andrea Proudlock discuss the property issues arising from greater integration in the healthcare sector.

Why this area is important

Estates and facilities could not be more important to the delivery of an integrated health system. When we talk about health services, we talk about the buildings: we refer to the 'hospital', the 'surgery', the 'clinic'. A physical environment is almost always required for healthcare provision, and the two are intrinsically interlinked.

Key issues

The estate needs to be available for the delivery of these integrated services. Currently, there are real tensions over land powers which bring into question where the ownership of the NHS estate really lies. To take one example, CCGs are tasked with delivering estates strategies but they have no direct legal powers to require trusts to make their land available. This can be problematic where a commissioner wishes to commission primary care or community services in an acute setting where there is a need to ensure all services are available to patients 'under one roof'.

Co-operation between the parties is essential to allow the integration of the services in the estate, but this can be hampered and creates tensions where a third party is seen to exercise control over an asset that has previously been viewed as solely within a trust's legal ownership, particularly where trusts come under political pressure to give up their estate to allow the service to be delivered from their estate by the most capable provider. Additional tensions arise where trusts are 'babysitting' properties and have no real long-term interest in them – if they are liable to lose ownership essentially at the commissioners' behest it leaves them unwilling to invest in what may be critical healthcare facilities.

With new models of care, commissioners are looking to ensure more services are provided within the community, with a big push to get patients out of hospital beds. Primary and acute care systems (PACS) and Multispecialty Community Provider (MCP) models mean more integration of primary and secondary care, and hospital trusts will find themselves needing to provide new capital facilities off their main sites comprising this accommodation. These might take the form of health villages, where there is real collaboration and partnership between the local authority, GPs and trusts. There is a knock-on effect in that trusts will also need to reconfigure services within their existing estate, enabling them to identify land which can be developed or reused.

Potential solutions

Full integration of healthcare services will take a long time to develop to maturity but in the short term there is an acute need for savings. Some efficiencies can be delivered through the restructuring of the delivery of estates and facilities services within trusts.

"We are already advising a number of trusts who are setting up structures to enable them to drive efficiencies in this area – these structures can be used in the future to enable trusts to work collaboratively to drive further efficiency savings," highlights DAC Beachcroft Associate Andrea Proudlock. However, she warns that there needs to be a unified approach to restructuring these services if this collaboration and integration is to work across trusts.

In a perfect world, there would be legislative solutions to afford more clarity on the powers of bodies such as CCGs in the development of estates strategies; their mandate to put those strategies into effect when they do not hold property themselves and they interface with NHS property holders. A unified approach to the delivery of estates and facilities services is essential to enable organisations in health – and more widely – to collaborate and deliver these services in an integrated way.

In the imperfect real world, however, constituent parts of the NHS that may once have been part of the same organisation, now find themselves on opposite sides of the fence and are working hard to rebuild and improve, in order to deliver truly integrated healthcare. Structural integration of the estate can be achieved through any one of many models. Key to this is to put the estate – and estates professionals – at the heart of decision making so that commissioning intentions can be supported by the healthcare environment, rather than the estate sometimes appearing to be hindering those intentions.

More information

For advice on estates and facilities, contact Anne Batanero on +44 (0)117 918 2037 or abatanero@dacbeachcroft.com if you are a trust in the south of England, and Andrea Proudlock on +44 (0)191 404 4098 or aproudlock@dacbeachcroft.com if you are a trust in the north of England.

AT A GLANCE

- Pressure is being placed on trusts to make more efficient use of estates
- Officials are keen for trusts to enter into partnership deals with private companies
- The integration agenda should take precedence over any pressure to form new estates partnerships
- Fundamental systemic tensions in the NHS estate need to be resolved to enable integration to take place successfully

A unified approach to the delivery of estates and facilities services is essential to enable organisations in health – and more widely – to collaborate and deliver these services in an integrated way.

Regulators

STRATEGIC / OPERATIONAL / REGULATORY / RISK

DAC Beachcroft Partner Corinne Slingo examines how the Care Quality Commission will inspect and regulate integrated healthcare services.

Why this area is important
The current model of Care Quality Commission (CQC) registration is provider-led: whichever organisation provides the regulated activity is the entity which is registered to provide the service and be inspected.

In future, where multiple provider organisations come together in an integrated care pathway centred on 'the patient', the vital question will be who becomes the provider entity for the purpose of regulation and inspection by the CQC.

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Providers want to know how regulation is going to work where you have a GP, an acute provider, a community care provider, and an independent sector provider - either individually or as a combined 'entity' organisation subject to CQC regulation – coming together to provide a seamless service which will, as a whole, require regulatory scrutiny under the CQC regime.

Key issues
Some Vanguard sites road testing integrated services have settled on creating separate legal entities into which all relevant providers on a specific pathway would fall. They effectively become a single provider entity under the inspection purview of the CQC, and registered in that form.

The CQC is mindful that regulation should not hold up the pace of change. Its 'Shaping the Future' strategy document sets out that registration arrangements should be a help rather than a hindrance to integration.

The CQC wants, in future, to register providers collectively under the badge of the service that they are providing, rather than on a provider-by-provider basis, a process known as 'registration by location'. For example, if one clinic comprises primary care providers and independent sector providers all in one place, it makes more sense to regulate that place of care delivery, rather than all the providers separately.

But integrated care providers urgently need to know who is going to be carrying the regulatory can for any regulatory breaches along that care pathway; where the lines of accountability may have become blurred. If there is some form of collective responsibility, how is it going to be enforced and where do the lines of accountability stop and start?

If something goes wrong under the 'registration by location' regime, is there a way to ring-fence that regulatory pain within that service? Or, where these providers are also providing services elsewhere, will enforcement activity bite back on general business and potentially have a detrimental effect on reputation and other income streams?

Providers are willing participants in integration but they fear that a registration and inspection regime that might impinge on other parts of their businesses would be unhelpful and provide a disincentive to further collaborative work; quite the opposite of the intended outcome of increased innovation and integration in how services are delivered.

Potential solutions
The CQC is working with NHS Improvement and NHS England on a solution to this dilemma. It has a designated person at each of the Vanguard sites to better understand how the regulatory landscape needs to change.

Providers in Vanguard sites need to be in close and regular communication with these local contacts. Those not in Vanguards or Pathfinders need to bring in the CQC at an early stage to discuss inspection issues around any innovations or service changes.

We have seen this approach working very effectively where providers want to do things that differ from normal practice. It is better to consult with the CQC registration team at the ideas stage, rather than wait and try to register something that is entirely new and may not neatly fit into the current CQC provider 'boxes'.

More information
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AT A GLANCE

- CQC is moving closer towards registration and inspection under the badge of the service provided rather than on a provider-by-provider basis
- When there is collective responsibility, care providers need to know where the lines of accountability stop and start
- Where services are changing the CQC should be informed at the earliest possible stage. The CQC does not want to be seen as a barrier to innovation and so it is imperative to involve local CQC relationship managers

Data protection

STRATEGIC / OPERATIONAL / REGULATORY / RISK

DAC Beachcroft Associate Eleanor Tunnicliffe considers the information governance issues when implementing integrated healthcare models.

Why this area is important
To provide integrated care clinicians need access to all relevant patient data. Typically, that data is held in silos. Some Vanguards are tackling this problem by creating shared care records for health and social care professionals that include information from a patient's GP records, the latest information on hospital visits and diagnostic results.

Key issues
Many patients already assume that GPs can access their hospital records electronically and are comfortable with this. More controversial is the sharing of data across the health/social care divide; GPs report patient concerns that records may be used to inform decisions around child custody or state benefits. Some projects allow patients to choose whether such sharing happens, with other projects making more limited data available.

There is a need to gain patient buy-in and ensure they have the option to access their care record online. Concerns around data security breaches are fuelled by doubt both outside the NHS (patients and GP practices) and from within. However, as human error is the most common cause of a security breach rather than the more commonly perceived risk from data hackers, a shared record held electronically in one place, and accessible by authorised individuals, is more secure than sharing via email or paper records.

GP support is critical, with substantial amounts of data held on GP systems. Unlike providers of secondary care, GPs won't typically employ IT and information law experts to support the process of introducing a shared care record system, making communication with GPs particularly important throughout the process.

In spite of Brexit, it is likely that the requirement of the EU General Data Protection Regulation (GDPR) will be passed into UK law, but there is uncertainty around how the GDPR will be implemented. Should the NHS pay the costs of ensuring new systems are GDPR compliant when there is no legal requirement to do this, nor a commitment from the UK government to implement the GDPR? Equally, there is no sense in developing systems that might not be GDPR compliant.

Potential solutions
The main legal barrier to information sharing is not the Data Protection Act 1998 or the GDPR but the law of confidentiality; sharing identifiable patient information is permitted to inform patient care, but not for use by NHS commissioners to inform other operational decisions.

There are questions around whether distinctions between what is and is not allowed really reflect patient concerns. Undoubtedly, some patients will want to restrict processing of their data but it is uncertain whether this is the attitude of the majority. There may be other dividing lines – such as whether or not data is shared outside of the NHS family. Dame Fiona Caldicott published a Review of Data Security, Consent and Opt-outs in July – known as the Caldicott 3 report – that starts to engage with these issues. It is clear that education and dialogue will be key for getting projects off the ground. But as the Caldicott 3 report highlights, the benefits for patients and the local health economy are substantial.

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AT A GLANCE

- Vanguard sites are creating shared care records that enable data from GP practices, hospitals and social care to be accessed in one place
- Data is held in discrete silos meaning there are technical hurdles to overcome in achieving a unified care record
- Patients are concerned about health information being accessed by social workers or benefits officials, and so dialogue between patients and GPs is key

NHS Improvement / Risk management

STRATEGIC / OPERATIONAL / REGULATORY / RISK

DAC Beachcroft Partner Anne Crofts discusses the role of NHS Improvement and risk management in driving integration.

Why this area is important
NHS Improvement brings together the Foundation Trust (FT) regulator, Monitor, and the Trust Development Agency (TDA), which regulated standard NHS Trusts. It replaces Monitor's Risk Assessment Framework and the TDA's Accountability Framework with a single oversight framework that will treat FTs and NHS Trusts in similar positions accordingly – unless there are good reasons not to.

Importantly, it also has a new key strategic role in supporting delivery of the NHS Five Year Forward View (5YFV) and will be required to approve Sustainability and Transformation Plans (STPs) for a five-year trajectory to 2021, with each STP's funding dependent on achieving a series of milestones.

NHS Improvement is still a developing organisation, establishing its new unified regulatory remit looking at standalone trusts and taking on its new role looking at whole health economies under the STP process. This will involve a different approach and a different emphasis.

Key issues
NHS Improvement will oversee and provide support with the aim of achieving a good or outstanding Care Quality Commission (CQC) rating. It will offer help around five themes; quality, finance, operational performance, leadership and improvement capability, and importantly, strategic change.

Under the latter heading, NHS Improvement will consider how trusts are doing in terms of delivering the changes set out in the 5YFV with a focus on STPs, and consider the Carter review's recommendations on how local health economies can come together to create efficiencies. It will be working closely with NHS England in this area.

Using the single oversight framework it will segment the sector and rate trusts in one of four categories: having no evident concerns; emerging or minor concerns; serious issues; or critical issues.

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NHS Improvement will offer optional support across the sector providing tools that can be drawn on to improve specific aspects of performance. And it will offer targeted support to help providers in specific areas – such as emergency admission or agency spend.

Where it has identified serious or critical issues that could find a trust in breach of its licence, NHS Improvement will offer mandatory guidance that could require senior managerial changes, the appointment of new management teams or agreeing a recovery trajectory and then supporting providers to deliver.

AT A GLANCE

- NHS Improvement will look to treat Foundation Trusts and Non Foundation Trusts in the same way
- It will regulate individual trusts and have an oversight and approval of Sustainability and Transformation Plans (STP) to achieve the aims of the 5YFV
- Individual trust assessments will also depend on how they are performing in terms of delivery of their local STP

Potential solutions
Well performing trusts can expect light touch regulation with less obligations on reporting, and more autonomy. Although oversight plans are still being shaped the overarching idea is to develop a common definition of what success looks like, and for FTs and NHS Trusts to be on equal footing in terms of regulation.

However, the legislative regime for FTs and NHS Trusts is still different; for example, FTs have broader freedoms and powers to set up new organisations, such as limited liability companies or LLPs to deliver care or back office services. This might be perceived as a potential barrier to FTs and NHS Trusts collaborating more closely across STPs, for example by establishing shared service companies, unless there is either greater consensus around how far trusts' powers extend in this area or there is a change in the relevant legislation.

NHS Improvement will have a direct role in scrutinising individual trust transformation plans under the new framework, although they will also have regard to how those plans fit in with the STP.

There will remain a level of scrutiny if, for example, a trust were to embark on a joint venture or partnership that involves risk over and above the level of statutory delegation.

NHS Improvement will also have a critical role in advising the Competitions and Mergers Authority on any trust's proposed merger or acquisition, which would need to be aligned with plans in STPs.

More information
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Workforce

STRATEGIC / OPERATIONAL / REGULATORY / RISK

DAC Beachcroft Partner Udara Ranasinghe and Associate Sarah George discuss the workforce implications of delivering healthcare integration.

Why this area is important
The integration agenda is driving the imperatives of achieving efficiencies, saving money and improving service delivery. But traditional employment structures are not appropriate for new models of care where different bodies work in more collaborative, fluid ways. In traditional care settings, be it health or social care, one organisation delivered a clear set of services. Now we are seeing workers from a range of organisations contribute to different elements of a care pathway. This is a real shift which must be reflected in new models of employment.

Key issues
Organisations on a care pathway might include social care, private bodies, charities, small primary care providers or hospital staff. The question is how to get employees to work with other people from different organisations where they may not be in a hierarchical role; they may not hold managerial responsibility for those people or indeed be part of the same body, or even part of the NHS.

New models of care need to define where liabilities lie for those involved in service delivery along the pathway. When there are major service redesigns that require staff to change locations or undertake different duties, this can throw up employment law consequences that may require consultation. Any resulting issues should be dealt with pragmatically as they occur. Radical changes in job descriptions might spark a need for a minimum period of consultation as they constitute redundancies under employment law.

Section 188 of the Trade Union and Labour Relations (Consolidation) Act 1992 requires minimum periods of consultation if 20 or more employees at one establishment are at risk of 'redundancy'. This period is 45 days if 100 or more employees are involved, and 30 days if its 20-99 employees. The definition of 'redundancy' is wider for these purposes than conventionally understood and would include cover where an employer intends to make significant changes to terms and conditions.

Employers must adhere to minimum legal requirements before changing employees' duties or contracts, which can prove an obstacle to new ways of working. The obligation to consult is principally around reducing redundancies and mitigating effects on employees. In addition, certain statutory information has to be provided to employee representatives. As this usually means consultation with unions, most NHS bodies engage in this consultation as a matter of course when the obligations are triggered. This is because attempts to circumvent consultation are likely to have a wider impact on partnership working with trade unions, or detrimentally affect industrial relations.

Unions generally prefer members to be employed by a traditional NHS body rather than a new hybrid with limited history, or a non-NHS body. However, unions are being pragmatic and are not making any principle objection to the creation of new legal bodies or the transfer of staff. Some disputes have arisen on a case-by-case basis such as where staff have to be TUPE transferred to a small private GP provider. Under this model it is important to define where responsibility for litigation might lie if things go wrong.

AT A GLANCE

- Traditional employment structures and working arrangements are not suited to delivering new models of care
- Service Level Agreements (SLAs), secondments, joint employment and the creation of third-party organisations are being used as vehicles to deliver more collaborative care
- New models of care must define where contractual, managerial and legal liabilities lie for each person or organisation involved

Potential solutions

Organisations are using Service Level Agreements (SLAs) creatively where contributors agree to the elements of the service they are providing. Staff remain with their current employer but work within a contractually agreed framework to deliver services alongside employees from other providers.

Secondment to a particular care pathway is also proving popular. It provides for flexible working as they can be started and ended fairly quickly. But secondments mean that a particular organisation's employees are subject to the control of another party, even though the employer continues to bear salary costs and legal liabilities. Under this scenario the substantive employer may incur a liability that it has no part in, or control over.

This can be mitigated by setting up a third-party organisation as a joint venture – for example as a charity or a limited company – to provide a particular service. Yet this has implications for pensions for NHS staff. Recent changes to the way staff have access to the NHS Pension scheme makes it easier for traditional non-NHS providers to access the scheme, but this remains an industrial relations issue with the unions wary of any potential detriment to staff pensions.

Increasingly, we are also seeing the joint employment model being considered; where an employee is jointly employed by two or more organisations to carry out services for them. The key to the success of these arrangements does depend on the clarity of understanding between joint employers on what they can expect from the employee and ensuring that neither feels that the duties to them are being compromised. Legally, the model raises interesting questions in relation to legal liability – where one employer acts in a way that might cause legal liability, the starting point will be whether the employee can sue the other or both employers.

More information

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