Editors' comments (and our responses):

Editors thought that your paper has something important to say about the current trajectory of the NHS. However, we still have several concerns about the clarity and focus of the argument, and the evidence and assumptions underpinning it. The comments here from the editorial team, including Fiona Godlee, are intended to strengthen your argument and make the underlying evidence more clear.

Like one of the reviewers, we thought that the central message of the paper was not easy to discern at present and suggest that your main, take home point is made clearly from the outset (and reflected in the title and introduction). The flow of the argument throughout the paper should maintain a clear focus on this core message.

We agree, and have significantly edited the paper and drafted a new conclusion in response. As regards a 'core message', we think that one of the main difficulties has been its composite nature, drawing together several different strands across health and social care to give the big picture. We have also chosen the quotes from politicians at the outset and at the end, and linked them to the title, with the intention of improving the clarity of the paper.

In your appeal letter you said: "Our fundamental difficulty with your reasoning (and the approach of Reviewer 1) is that they miss the big picture that the paper is seeking to describe. This is the first time that a paper draws together the historical legal development in respect of social care with the data on service delivery and changes to funding, and links them to the legal changes in the NHS in 2012 and devolution in 2016 providing the context for the Sustainability and Transformation Plans. These provide the bases for reaching reasoned conclusions on the direction of travel for the NHS and provision of health services – which is more than borne out by current reporting of the situation of the NHS in England."

However, the paper does not set out the reasoned conclusions clearly enough nor does it fully describe the supporting evidence. This needs to be much clearer and easier to follow so that readers do not also "miss the big picture", as editors and reviewers have done.

We agree, and we have now sought to make it clearer. We also think that the argument needed a clearer linking in of the radical regressive changes to the local government finance system, and so have included that.

As per one of the earlier reviewers, we thought that one of the interesting aspects of this is how we are going to resolve the disconnect between the free at the point of care health service and the means testing in social care. This might be a useful and fresh angle for the paper.

We agree that this disconnect is central, and we have made clear that there is no evidence that this is being addressed.

Reviewers' Comments (and our responses):

Reviewer: 1

This paper draws on changes in the funding and delivery of adult social care to discuss challenges facing the NHS with a particular focus on the privatisation of services.

The paper is wider than that.

Specific comments are:

p. 3 the 2012 Act may have given FTs the ability 'to generate half their income from non-NHS work' but very few get anywhere near this

Our point isn't about achieving a target figure. Rather it is that FTs are now able to significantly increase their income from non-NHS work. With balancing the books and making a surplus key performance requirements, they will shift focus to maximize this income – which, with increasing provider debt will lead them, and NHS trusts, to reduce and ration NHS services and divert bed, staff and services to generate private income. As services fall out of the NHS this will result in user charges including private health insurance for previously freely provided care.

p. 3 to claim that the Devolution Act allows LAs 'to take over health service functions' is a misleading simplification.

We do not consider this to be either a 'claim' or to be 'a misleading simplification'; it is an accurate description of the legal position.

The title to section 16 of the Cities and Local Government Devolution Act 2016 (the relevant section) is "Power to transfer etc public authority functions to certain local authorities"; and NHS England has described this as "Function is taken away and given to another legal body on a permanent basis (meaning responsibility, liability, decision-making, budgets and everything else to do with that function) by a transfer instrument under the Devolution Act [..]": see page 7 (Overarching model 4) of 'Devolution - What does it mean from an NHS England perspective?' https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/05/devolution-publication.pdf

The GM experience is not a take over but a coming together of the NHS and local govt in the conurbation with accountabilities unchanged.

We were stating what the Act permits, not describing 'the GM experience'. In any event, 'Devo Manc' is proceeding, at this point at least, without secondary legislation which transfers health functions.

NHS organisations continue to run their services and do so in collaboration with local government partners. Decision making remains firmly in the hands of the NHS as does funding.

NHS organisations running their services (with local authorities) does not seem to us to be an apt description of the £5.9 billion contract being tendered for health and social services (which we now include in the paper). It is, rather, a description that fits better with the view that the NHS has been dismantled and structurally replaced around commercial contracts, funding streams and an NHS logo. Furthermore, the use of private-public debt finances for funding capital plans for STPs does not suggest that decisions about funding will 'remain firmly in the hands of NHS'.[https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2016/09/service-support.pdf]

p. 4 onwards is a lengthy history of changes in adult social care which could and should be much shorter and more succinct. This territory has been well trodden by others

We deal with this now in a different way. We are not aware of the underpinning statutory changes having been covered elsewhere, and have made this aspect more succinct and woven it differently into the narrative.

p. 6 the authors need to be much more specific when they refer to the 'weakening and shifting of statutory functions' in the 2012 Act.

We have not used this phrase in this version of the paper - not because we think that it was incorrect or not sufficiently specific (it was used in the previous version to refer back to the specifics that had been set out earlier in the text), but because we have changed the narrative in order to make the paper clearer.

The Health Secretary continues to exercise oversight of the NHS and to take a very close interest through his Monday meetings. He is also held to account by Parliament. The Act has made some difference with the creation of NHSE and the more prominent role of its CEO but this should not be overstated

The daily activities of the Secretary of State and of accountability to parliament are beside the point – they take place in the context of the statutory provisions, and the duty to provide no longer exists.

p. 7 NHS budgets are already being used to fund social care in some parts of the country - Oxford being a well known example but there are many others

In the original text we used The Better Care Fund as an example of NHS funds being used to support other non-NHS services. It differs from other local examples due to its size and top down approach.

In the new narrative, we make this point using the public health grant - which despite ring fencing was used by local authorities to support other council services.

p. 7 the article confuses STPs and the Sustainability and Transformation

Fund (STF). The latter is the £1.8 bn referred to here and is different from STPs.

Yes the 1.8bn referred to the STF and not the STPs in our original piece. We do not make reference to the fund in the new narrative.

The story about STPs is not just about cuts but about plans to improve and transform care. The one sentence statement beginning 'The plans show the scale...' is a wholly inadequate characterisation

We do not use this sentence now in the paper – again, not because we considered it incorrect, but because of how our consideration of STPs now fits in to the narrative. (As to the reviewer's comment, we note that he does not questioning the accuracy of what we were saying; as to inadequacy, the paper was not, and is not, a paper about STPs, but about STPs as one (important) factor in the context of the several changes and processes underway.)

p.8 the conclusion is overblown and overhyped e.g. 'spell the end of a universal national health services' (sic) - the evidence presented does not support this assertion

We consider that the paper draws together a substantial body of evidence, and applies an analysis and narrative that powerfully supports such a conclusion – though we have used different language in the current paper to say the same thing.

General points

Devolution in the NHS is at present confined to GM and with the change of PM and CHX in the summer the indications are that there is much less interest in taking devo forward in other areas (at least as far as the NHS is concerned).

As yet, health devolution under the 2016 Act, which requires secondary legislation, is not happening anywhere, as the secondary legislation to do that has not been made. In the paper (except once in the Conclusion, when we place the word 'devolution' within inverted commas to indicate that we are not using the term there only in its precise technical sense), we use the word 'devolution' to mean devolution under the Act; NHSE's language, of the 'devolution spectrum' and the 4 models (see link above) is both useful and potentially confusing. The change of PM and CHX is as may be – our analysis is based on what Parliament has authorized.

It is really important to be clear what Devo Manc does and does not involve.

We agree entirely.

In passing, it is worth noting that it is not easy to establish given the lack of transparency in which 'the deal' was made and the absence of

legislation, such as that which accompanied devolution in Scotland and Wales. (Remarkably, the four documents posted on the government's website setting out the terms, apparently incrementally, are undated: https://www.gov.uk/government/publications/devolution-to-the-greater-manchester-combined-authority-and-transition-to-a-directly-elected-mayor).

The BMJ has covered this in a previous paper.

We assume this is a reference to Walshe et al, BMJ 2016;352:i1495, entitled 'Health and social care devolution: the Greater Manchester experiment'.

Local authorities and NHS organisations in GM retain their current accountabilities and responsibilities. Local government has in no way taken over the NHS. There is some 'delegation' in GM but nothing that approaches 'devolution' as most people would understand this.

The Walshe et al. paper states: "The devolution of health and social care builds on a growing devolution movement in England in which central government is agreeing to hand over powers to local government…The proposals for Manchester are the most radical and advanced manifestation of the policy to date." That description differs from the reviewer's assessment of "some 'delegation'" in GM but nothing that approaches 'devolution' as most people would understand this."

NHSE's document referred to above – 'Devolution - What does it mean from an NHS England perspective?' – includes 'delegated commissioning arrangements' as the third overarching model in its description of the 'devolution spectrum'.

Our view is that 'devolution' should be used to mean devolution under the 2016 Act, and the paper dos that (save once in the Conclusion, as explained above).

In my view GM is an attempt to coordinate planning and decision making between the NHS and local government in GM i.e. it is seeking to achieve closer integration of health and social care (and other public services) at scale. There are characteristics of GM that are not found elsewhere.

This view is unsubstantiated. The size of the Local Care Organisation contract shows the extent to which NHS and local government will no longer control planning or provision of services, or have the ability to respond to needs. The lack of transparency about decision-making, which services are being privatised and how and which needs will be met is also a significant departure from joint service planning.

Extrapolation form this example to 'the end of the NHS' is hazardous to say the least. the authors need to provide concrete evidence of how Devo Manc is leading to privatisation etc to make their claims stand up and they

fail to do so.

We were and are not extrapolating from a single example. Our analysis is based on an appreciation of the statutory provisions, the evidence of previous and current experience, and the funding position in the NHS and local government. The current tender for the Manchester Local Care Organisation contract is exactly in line with what we were predicting.

The NHS and social care both face huge pressures and this is impacting on patients and users. But the causes are primarily lack of funding at a time of rising demand - as the BMJ has covered extensively. Devo is a very small factor in understanding what is going on and in seeking to understand what might happen in future. Put simply, there is less to Devo than meets the eye

We agree that devolution alone is just one factor in understanding what is going on, however it must be seen in the context of the wider changes which we describe in the paper.

Reviewer: 2

Thank you for asking me to review this article. You ask for my advice on

a) the importance and relevance of the topic to a general readership?
b) whether the article covers the topic well and in some depth?
c) whether the authors make their case well , either through reasoned argument or through drawing reasonable inferences from the available data?.

Taking each question in turn:

a) importance and relevance of the topic to a general readership?

This paper explores the association between legislation, funding and provision of health and social care in the UK. These are important issues with profound implications for the nature of health and social care in the UK, and as such are important and highly relevant to a general readership.

b) whether the article covers the topic well and in some depth?

The paper brings together a variety of relevant data, that though publically available, are unlikely to have been seen by the majority of a general readership. It also describes selected elements of some significant health and care legislation of the past few decades. So, in the sense of the provision and presentation of information, the article covers the topic well and in some depth. I comment more on the method, analysis, and construction of an argument in the next section.

c) whether the authors make their case well , either through reasoned

argument or through drawing reasonable inferences from the available data?

Generally, we have found this reviewer's comments helpful and they have influenced how we have edited the paper.

General comments

1. I read the paper several times and initially struggled to properly understand the question that is addressed by the paper and then to follow the method and argument being made to address that questions. However, I think the question and approach is desribed in the paper with, if I have read it correctly, the key question being addressed by the paper being…

what are the likely implications for nature and volume of the provision of health care following the significant changes to the 'organisation, delivery and funding of health and care services….since .. the Health and Social Care Act 2012" ?

and, the method the authors use to address the question is to look for parallels between post 2012 health legislation with previously introduced social care legislation and then, where such parallels exist, explore the impact on the provision of social care and then conclude that similar consequences are likely to be seen in the future provision of health care. If I am correct in my understanding, then I think the paper could be presented in a way that sets out the question and describes the method more clearly to make it easier for a reader to follow the intellectual argument of the paper.

We appreciated this comment and have restructured the paper.

I think it would also be helpful to describe the strengths and weaknesses of the links between data, deductions and predictions so that readers can more readily form their own view about the strength of inferences to be drawn from the data.

We agree that this traditional clinical paper approach is a helpful model, and we have borne this in mind in constructing our 5-step narrative.

2. The title of the paper includes the phrase… "the road to privatisation". I think it might be helpful to distinguish more clearly between privatisation of funding (commercial insurance, self pay, user co-pay etc) and privatisation of provision as the access, equity and volume implications of different combinations of private/ state funding and provision (publicly funded, publicly delivered ; publicly funded, privately delivered: privately funded, publicly delivered; and privately funded, privately delivered) can be very different.

We have a new title, and have tried to be more specific in the text.

It may also be helpful to set out the likely consequences of the changes

on the nature of provision that the authors predict from their analysis on the ability of the NHS to continue delivering key principles such as universal timely access to good quality care, care free at the point of delivery, resources allocated according to need not ability pay.

Our analysis suggests that as the NHS withers away due to cuts and closures and transfers of care to local authorities, equity and universality on the ground will be increasingly eroded, following on from their abandonment in the 2012 Health and Social Care Act. Resources and access will become increasingly difficult to monitor as care is shunted into the private sector.

Specific points

3. Page 1 until line 14 page 2 describes some of the important legislative changes and policy developments since 2012. I wonder if a table setting out the legislative and policy developments and their key features would be a helpful and a more succinct way to convey the same information.

In response to this comment we initially summarized this information in a table, but later realized that as we have changed the Introduction, a table no longer seemed to add anything, so we did not include it in the end.

5. P2 lines 17-23 I think this paragraph is essentially the 'method' section of the paper. I think it would be helpful to expand this, explaining more about the parallels looked for, methods for attributing changes in delivery to policy (time lags, changes in trend, absence of other changes that might have contributed to observed effects on provision etc). Somewhere it would be helpful to have brief discussion of the strengths and weaknesses of this method of analysis.

On reflection, we thought that a traditional 'methods' section was not the best way to present what we have done, but rather to construct and set out our 5-step narrative.

6. Given that a key point of the method is comparing recent health care legislation and policy changes to earlier social care legislation and policy change, I would have found it helpful to have a side by side table of NHS and social care legislation where the authors see significant parallels. I think this would help readers understand the extent of the similarities.

We also initially thought that this was a good idea, and began to compile a table, but as we constructed what we think is a clearer narrative, it seemed to us that the legal changes needed to be woven into that narrative better rather than to make a 'simple' comparative point, so we did not in the end take up this suggestion.

7. The next section describes changes to social care legislation and observed changes to the volume and nature of provision. From what I think I can see from the data, much of the total volume of provision is

closely related to the availability of funding (e.g. the decline in recent years of funding for social care is strongly associated with decline in numbers of people in receipt of state funded social care), but the nature and ownership of provision is more heavily influenced by policy and legislation. If that's correct, I wonder if that is a conclusion worth stating.

We agree and have made this clearer in the text, illustrating that provision is closely related to funding, and outsourcing requires the initial statutory framework, but also the right incentives and environment.

8. I also wonder whether or not the data justify the implied inference of causation rather than association that the authors draw. Perhaps a discussion of why the authors believe causation rather than association / confounding is the correct conclusion to draw should be included, not least because there appear to be significant changes in trends observable in the data that are not obviously explained by the narrative text suggesting there are other significant explanatory factors that have not been identified or discussed. For example in Figure 1 (as an aside , it would be helpful to identify in the figure the key legislative events eg the 1972 and 1990 Acts referred to in the text) the 1990 Act does not appear to be associated with any change in the rate of growth of privately owned long stay beds. Indeed the rapid growth in these privately owned beds appears to have started in in the late 1970s early 1980s which does not fit well with either the 1972 or 1990 Acts being the prime cause. So generally, I would have found it helpful to have the authors views about explanations for the timing of major turning points in the data that they present.

The change in bed ownership was dependent on the legal framework to outsource, but then funding changes were necessary to encourage use of the legal powers. We have made this clearer.

9. I am sympathetic to the case that the authors are making about threats to the future of the NHS, but I sometimes wondered about the tone. For example, the last para (lines 16-19 page 8 states 'devolved health care agreements…spell the end of a universal national health services (sic)' . I wonder if that's overstated , not least because there have always been marked variations in provision in the NHS.

We do not use this phrase now, but as we stated above in response to Reviewer 1, we consider that the evidence, analysis and narrative in the paper strongly supports such a conclusion, which goes far beyond 'simple' marked variations in provision.

Similarly language such as 'under the guise of' implies motives that may or may not be correct. And depending on the judgements about causality v association, it's probably important to be careful to review choice of words that imply causation such as "resulted in" when "associated with" might be more accurate, and when thinking about the future saying

something “will” happen when “may” might be more accurate.

We consider that our prediction of what will happen is amply supported by the evidence of what is happening now, and what has happened in the past.

Summary

I think the authors write about an extremely important topic. I think the data they present is both important and interesting, and they have chosen an interesting method for analysing the data and considering the implications it might have for future NHS provision. However, I think the arguments being made could be better set out and the inferences drawn from the data could be better explained and justified.

Once again, thank you for asking me to review this interesting paper. I hope my comments are helpful.

Shailen Sutaria
Peter Roderick
Allyson Pollock
13th April 2017