Are NHS cleft services in England ready for delegation to integrated care systems?

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Key points

UK cleft services have had financial stability through national funding for 25 years following centralisation.	The funding structure of cleft services in England will fundamentally change in 2024 with the delegation of NHS commissioning to integrated care services and allocation of resources on a regional basis.	While integrated care services can potentially address some of the inequities currently known to exist in cleft care, they also threaten the major clinical advances that have been gained over the last two decades.

Abstract

Cleft care services in the UK have been nationally funded since centralisation 25 years ago and during this time have been able to demonstrate improved clinical outcomes. Integrated care systems have been introduced into legislature as part of the Health Care Act of 2022 and will be responsible for the paradigm shift of allocating funds on a regional basis for cleft care services in England from 2024. The proposed population-based funding formulas present an opportunity to improve current inequities in cleft care, including access to speech therapy and adult services. However, the regional footprint of integrated care systems does not align with that of the centralised cleft service system and represents a threat to the standardised patient-centred care that has taken two decades to build. Awareness needs to be raised so that cleft care providers can proactively adapt to this mandatory change to service funding to ensure that clinical standards are maintained and continue to improve.

Introduction

For the past 25 years, UK cleft lip and palate services have been organised in a centralised hub-and-spoke model and feature highly specialised interdisciplinary team working, a national service specification, a dashboard of key performance indicators and a national audit system (Cleft Registry and Audit Network [CRANE]) with unit-level outcome reporting and accountability.[1,2,3] The combined impact of a fundamental restructuring of services following the Clinical Standards Advisory Group (CSAG) report in 1998 and the formation of the world's largest cleft research collaborative has enabled UK cleft care to achieve world-class status, demonstrating the NHS at its most innovative and capable.[4] The Cleft Care UK study demonstrated improved aesthetic and functional outcomes following the centralisation of services in 2000 (see Table 1).[5,6]

Funding for UK cleft services has been ring-fenced via a national allocation. In Scotland, Wales and Northern Ireland, national funding for cleft has been allocated within integrated care systems that can be traced back to the respective devolutions from 1999–2001. In England, the funding allocation is set to change with the introduction of integrated care services (ICSs) into the legislature. This opinion article aims to review the historical

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Table 1 Examples of advances in UK cleft care over the last 20 years since centralisation

Area of cleft care	Evidence of progress
Clinical standards	The 2022/23 NHS dashboard specifies 12 key performance indicators for cleft lip and palate services.[7] Clinical standards have been published for newborn examination for cleft palate,[8] speech outcomes[9] and medical photography[10]
Clinical outcomes	In 1998, CSAG reported Britain's fragmented, decentralised cleft services were achieving a low standard of clinical care in key areas.[11] The 2017 Cleft Care UK study reported improvement in clinical outcomes following centralisation, with notable gains in facial growth and the attainment of normal speech.[12,13] Parent surveys have suggested improved satisfaction with services following centralisation[2]
Cleft team structure	All cleft teams in the UK provide comprehensive multidisciplinary care as stipulated by the UK NHS Standard Contract for cleft lip and palate services[14]
Audit	The national audit network (CRANE) have reported national audit outcomes at five years of age since 2012 in their annual report.[1] Outcomes include speech, facial growth, dental health and psychological wellbeing
Research	The Cleft Collective is a national longitudinal cohort study which investigates the aetiology, treatment effectiveness and psychological impact of cleft.[15] Published findings from the Cleft Collective are providing important insights into cleft care[16,17]
Training	The CSAG study recommended a common training pathway for cleft surgeons and subsequently the Cleft Training Interface Fellowship was established, which continues to provide interdisciplinary quality-assured training[18]

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funding of UK cleft services and consider the impact of ICSs for the delivery of specialised cleft care in the England.

Historical funding of NHS cleft services

At the time of UK cleft service centralisation in 2000, contracts for the 12 newly formed cleft service networks were negotiated on an individual service basis, influenced by regional cleft births. In England, NHS primary care trusts (PCTs) delegated funding responsibility to specialised commissioning groups, but following the 2012 Health and Social Care Act, PCTs were replaced by clinical commissioning groups (CCGs). In this new system, 'specialised services' (there are currently 154 specialised services, of which cleft services are one) benefited from funding at a national level, overseen by NHS England and NHS Improvement (NHSE/I).[19] This means that since centralisation, cleft services have retained similar annual contracts that were originally negotiated from the outset in 2000.

Despite the financial stability over the past two decades, concerns have been raised about the inequity of cleft care commissioning, which was viewed by some cleft service clinical directors as failing to allocate resources according to clinical needs.[20] Examples of inequality in cleft care have been highlighted in recent years, including considerable local and regional variation in the funding and provision of cleft-related speech and language therapy and difficulties for adults with cleft to access care.[21,22] Furthermore, the COVID-19 pandemic further magnified these pre-existing inequities, presenting additional challenges for post-pandemic recovery.[23]

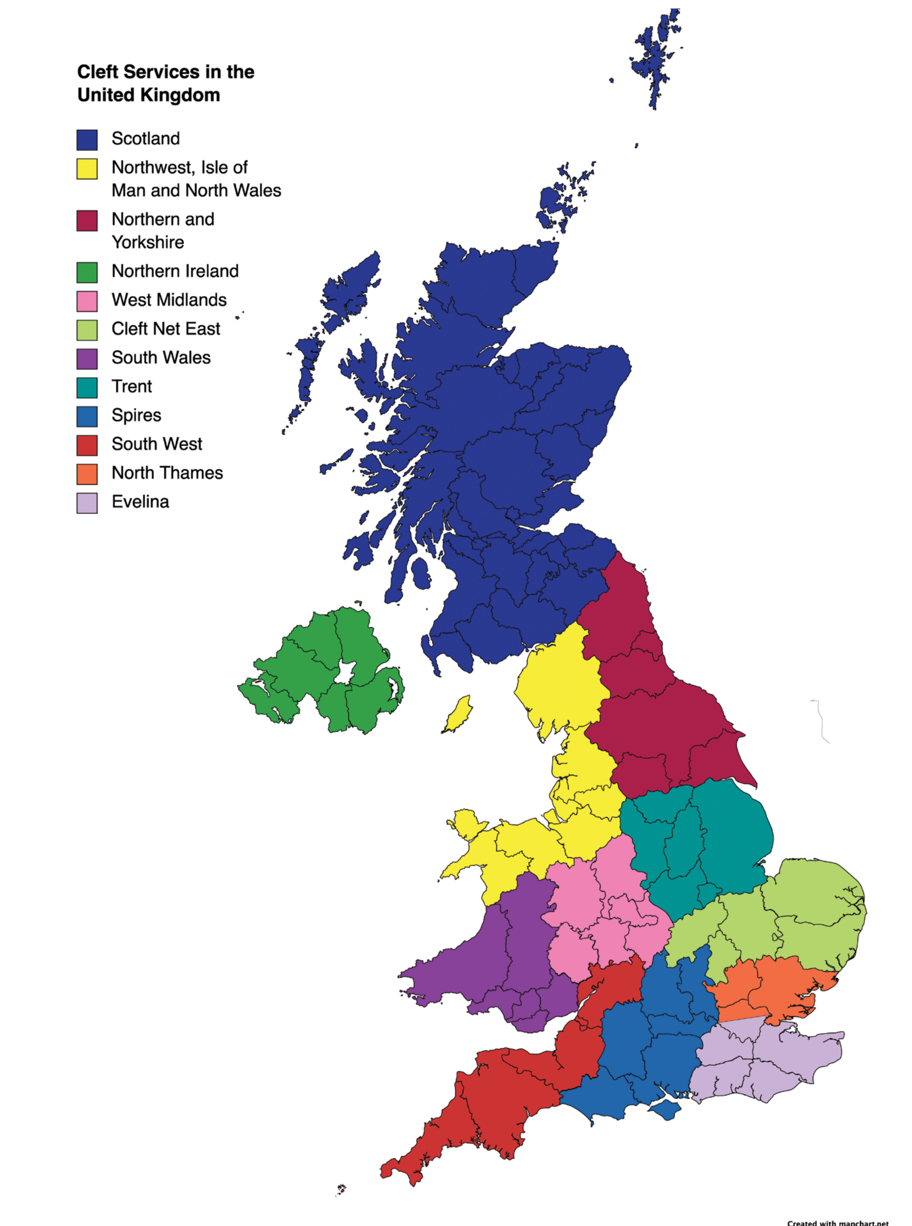

Fig. 1 The 12 cleft services in the UK. Nine of the cleft services have their hub centre located in England. County boundaries have been used for convenience, although this is not accurate for all services. Map created in Mapchart.net and used with permission

Integrated care systems

The Health and Care Act 2022 introduced ICSs into the legislature.[24] This reorganisation saw 42 ICSs in England replace over 100 CCGs, with the aim of maximising cohesive high-quality and equal care, which is more responsive to local health needs.[25] Each of the 42 ICSs has an integrated care board (ICB) responsible for budget allocation and an integrated care partnership responsible for strategy. The key change is that funding will move to regional, population-based allocations for health care services via delegation to ICBs. It is notable that ICSs have come into statute with little fanfare, yet the detail on specialised services commissioning, which accounts for a significant proportion of the health care budget was only mentioned 20 times in the passage of the bill.[26] Subsequently, guidance on specialised service commissioning has started to emerge and evolve.[27,28]

Cleft lip and palate services are one of 59 specialised services assessed via a pre-delegation assessment framework as being ready to transition to ICB commissioning from April 2023.[29] The framework assessed readiness to transition according to six key domains: health and care geography; transformation; governance and leadership; finance; workforce capacity; and data reporting structure.[30] During 2023, NHSE/I will continue to commission nationally according to the historical arrangements already in place. From April 2024, nine geographical footprints in England, formed from multi-ICB collaborations, will determine future allocations via a needs-weighted population-based funding formula. These geographical footprints bear resemblance to, but are not the same as, the geographical distribution of the 9 of 12 UK cleft services that are in England (Fig. 1, Fig. 2).

There have been reassurances that NHSE/I, through the Advisory Committee on Resource Allocation, will put safeguards

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in place to ensure the pace of change for funding transitions are appropriate, with the aim of avoiding any dramatic changes. Furthermore, NHSE/I, together with the Care Quality Commission (CQC), have pledged to retain national accountability for specialised services and determine what they need to deliver, giving ICBs the freedom to determine how they deliver it. From April 2023, NHSE/I will establish a delegated commissioning group for the specialised services deemed appropriate for ICB commissioning, which will manage approval of national standards, approve gateways for national transformation programmes and guide support to the nine regional multi-ICB collaborations.

Opportunities

An independent review has labelled ICSs as the best opportunity in a generation for a much-needed transformation of the NHS health and care system in England.[31] For cleft services, ICSs may represent an opportunity to improve access and quality of care in areas that have been identified as inequitable by being more responsive to local demographic needs. Rt Hon. Patricia Hewitt identified key principles in making ICSs successful and NHS cleft services have notable strengths in the areas identified (see Box 1).

Threats

Of concern, multiple independent commentators have acknowledged that ICSs have been borne into challenging circumstances, which include post-pandemic backlogs, relative politico-economic instability, staff shortages and NHS industrial strike action.[31,32] This is a concern for cleft services as the introduction of ICSs represent the greatest financial upheaval since centralisation in 2000. With so much at stake following documented improvements in cleft care clinical outcomes, it is imperative that the right balance is reached between allowing ICBs the freedom to commission yet ensuring clinical standards are maintained. Box 2 explores the potential threats to the NHS cleft service following delegation to ICBs.

Knowns and unknowns

ICSs have been written into the legislature and cleft services have been identified as ready for delegation. The advantages of ICSs include the promotion of collaborative working to develop responsive care pathways, thus reducing health inequalities and are highly relevant to some of the challenges facing cleft care in the UK today. Yet it is concerning that levels of awareness about ISCs among cleft providers in England are low and many questions are still to be answered.

National and regional cleft care leaders will need to engage with the re-organisation at every possible opportunity provided. Cleft services will need to be flexible and adaptable to the inevitably burdensome structural changes that will incur. To this end, the Craniofacial Society of Great Britain and Ireland has created an ICS hub to raise awareness and help cleft care providers to access up-to-date information.[33]

Of paramount importance is the need to maintain hard-fought national standards, particularly as ICS changes at all levels permeate the infrastructure of cleft care. The rightful involvement of patients and their families in informing proposed changes to the delivery of cleft services and research should be promoted wherever possible to maintain faith in service users that cleft services are designed with them in mind, while heeding the requirement for financial streamlining. Existing data streams in cleft care, such as the CRANE database, should be prospectively prepared to monitor and publish the impact of the change and their ongoing funding secured. There should be a culture of openness encouraged from all

Fig. 2 The nine geographical footprints in England for the proposed ICB collaborations. These geographical footprints bear resemblance to, but are not the same as, the geographical distribution of the nine cleft services in England. Image used with permission from NHS England[30]

Box 1 Components of NHS cleft care that will help to make delegation to ICSs a success

- Collaboration: the multidisciplinary nature of cleft care is built upon a foundation of collaboration. Cleft services are accustomed to regularly joining with two or three other services (tri- and quad-centre audit initiatives) to compare outcomes and work collaboratively
- Data: CRANE collects and publishes data in the form of a registry and an audit of clinical outcomes and is considered globally as a unique strength of UK cleft care. This strong and transparent system of data management will enable cleft care to analyse the regional and national impact of ISCs
- Voluntary network: Cleft Lip and Palate Association is the UK's support group for people affected by cleft and has an established a pivotal role in providing information for patients and their families, as well as patient and public involvement initiatives to guide clinical decision-making and research endeavours
- Clinical leadership: the Cleft Development Group (CDG) is a national independent body of cleft stakeholders that has advised the government for the last two decades. The CDG overseas the Quality Monitoring and Improvement Committee which aims to ensure safe, effective and patient-centred cleft care.

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Box 2 Threats to NHS cleft care following delegation to ICSs

- Complexity: multiple layers of bureaucracy will potentially increase the administrative burden for cleft teams. How will the 12 cleft team networks be retrofitted into the nine multi-ICB collaboration geographical footprints in England and what will be the impact on service delivery?
- Oversight: the relationship between the oversight bodies (NHSE/I, CQC), the ICSs/ICBs and the cleft care providers is ill-defined and relationships may be uneasy. How will the significant improvements to the standards of care over the last two decades be maintained and what will the path of accountability be?
- Funding: a key aim of ICSs is to improve value for the British taxpayer. Specialised services such as cleft are expensive and account for a significant proportion of the health care budget. The allocative mechanism for finances is far from clear but will increased value equate to cleft services being expected to deliver more for less?
- Equity: a key aim of ICSs is to improve equity, but some ICSs are more established than others and have differing levels of expertise with a variable knowledge base of the cleft specialty. How will the allocation formula be fine-tuned to ensure resources are allocated fairly?

stakeholders about the advantages and trade-offs with ICSs so that we do not look back in another decade with regret.

Conclusion

The delegation of cleft services to ICSs/ICBs is significant as it represents a change to the relative financial stability that has been in existence for the last two decades. NHS cleft services in England have been deemed suitable for delegation but that is not the same as being ready for delegation and a high level of careful preparation will be required at all levels. This will include the design of solid, overarching frameworks with transparent funding strategies at the NHSE/I level, necessary upskilling and capacity building at the ICB-collaboration level, and administrative preparedness at the cleft service level. Short-term disruption will be inevitable, but it is in the interest of both cleft patients and cleft professionals that we work collaboratively to get this right.

Ethics declaration

The authors declare no conflicts of interest.

Author contributions

Matthew Fell: guarantor who has contributed to all stages of the article and is responsible for the overall content, accepts full responsibility for the work and conduct of the study, has had access to the data and controlled the decision to publish. Ambika Chadha: involved in planning and manuscript editing. Simon Van-Eeden: involved in planning, manuscript editing and supervision.

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