Briefing

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NHS CONFEDERATION

Implementing the NHS Long Term Plan: Ten key issues for the proposed legislative changes

Introduction

The NHS Long Term Plan sets a bold direction of travel and there is now a real opportunity to deliver a new vision for the health service with joined-up care at its heart. All of us know this will not be straightforward, that it is an extremely challenging agenda and that success is by no means guaranteed. But we also know there really is no alternative.

At the heart of this is a determination to move towards much greater collaboration and system working. To help facilitate this NHS England/Improvement have reviewed the existing legislation and has consulted on a number of proposals which seek to remove barriers to collaborative working.

The NHS Confederation has been engaging with its members to gauge the views of front-line leaders on the proposals. Broadly, there is support for the direction of travel and we support the push to promote and enable greater collaboration and to remove some of the existing (or perceived) barriers to this. We recognise that the NHS is in a different place from when the 2012 Health and Social Care Act came into force and that several aspects of this legislation do act as barriers to effective integration.

We also acknowledge that while it will not be possible or desirable to undertake wholesale changes to the existing legislation, there is a case for targeted changes. Hence it is important that we evaluate whether these proposals can help accelerate integration and provide the NHS with a coherent legislative framework.

From our discussions and engagement with front-line leaders, ten key issues have emerged. It will be essential to address these if we are to create the right legislative and regulatory framework for local leaders and their organisations to succeed:

1. Where does accountability lie in the new world, and how will the governance arrangements of joint committees be clarified?
2. Do these proposals risk over-centralising power?
3. Do these proposals undermine the principles of the foundation trust model?
4. What do the proposals mean for future trust mergers and acquisitions?
5. What does the introduction of the 'best value test' mean for choice and competition?
6. What will the accountability and governance arrangements of integrated care trusts look like, and do they risk leaving community and mental health providers with a diminished voice?
7. Will these changes enable more joined-up commissioning?
8. What do the proposals mean for public accountability?
9. Will the proposals increase the flexibility of national NHS payment systems?
10. How will the leaders of front-line organisations be consulted on the proposals before they are finalised?

Ten key issues

1 Where does accountability lie in the new world, and how will the governance arrangements of joint committees be clarified?

At the heart of the issues raised by provider trusts and clinical commissioning groups (CCGs) is a tension between the hard accountability they face to their boards or governing bodies and their responsibilities for playing a full part in their local systems. Front-line leaders recognise that increasingly they have dual responsibilities. However, given that the new and emerging integrated care systems are not planned to be legal entities, the proposals as they currently stand will leave some tensions in the system unresolved.

In particular, a key question will be how these changes impact on the authority and autonomy of unitary boards which are accountable for the activities of a trust. There is real concern among foundation trusts in particular about being held to account under the old system while at the same time being expected to pool or sacrifice some of their autonomy. Whatever new system of accountability is devised, it will need to reflect an emphasis on pooled sovereignty and collective decision making.

We support the proposal to create joint committees to oversee decisions across systems – or even places. It is important that these committees involve commissioners and all types of provider and enable strategic conversations about service needs. These committees should involve local authorities, voluntary, community and independent sectors, who provide and commission critical services in the local health and care economy. This cannot be an inward-looking process just involving NHS organisations.

Joint committees could help to speed up the move towards greater integration. There is however a need to be clearer about the specific roles and responsibilities that commissioners and providers would have in these arrangements. The joint committees will need to draw on the expertise of providers in the design of patient pathways and be explicit in what decisions cannot be made jointly and will be reserved for commissioners only.

Back in January, NHS England chief executive Simon Stevens, when discussing the roles and responsibilities in integrated care systems, said there is clear benefit from having distinction between the planning and funding – or commissioning functions – and the day-to-day delivery of clinical care. Ensuring someone in the system retains that mindset means there is someone who can look across a population and say: "How do services need to change?".

We will need further detail on how accountability and governance for these joint committees will operate, particularly whether the trusts and CCGs that come together in a joint committee will remain individually accountable for the decisions they make collectively (as we expect will be the case). The proposals suggest that the creation of joint committees would be at local discretion, but it remains unclear what would happen if one or two organisations decided they did not wish to be part of a joint committee that every other organisation supported.

It will also be crucial to understand and manage any conflicts of interests that may arise, and this will require an understanding of what can and cannot be considered by the joint committee. We believe that the new committees should not undermine the unique role of commissioners in making decisions around procurement, awarding contracts and making sure local resources are being used effectively.

2 Do these proposals risk over-centralising power?

The joining up of NHS England and NHS Improvement is welcome. It should result in an end to the sometimes-contradictory messaging and direction that front-line NHS organisations have experienced. But we need to avoid creating a large and all-powerful organisation which is too big to challenge and too large to function effectively. It must be able to balance its roles of regulating and supporting NHS organisations and it will need to have the right culture and appropriate checks and balances.

Their joined-up leadership should hopefully lead to aligned assessment frameworks, with what is measured and assessed made clear from NHS England/Improvement. It would be helpful to have a single set of reporting on services. This should also consider the role of other regulators, such as the CQC, which has an important role in encouraging collaborative working through its system reviews and how it assesses providers.

However, while this may not be the intention, the proposals risk swinging the pendulum of power further to the centre and away from local NHS organisations. As we called for in our *Letting local systems lead* report, we need to see local systems handed greater autonomy and control over what happens in their areas, but these proposals may not aid this. There is a risk that the centre will have more opportunity and authority to intervene in the activities of local NHS organisations and systems, and that is a cause for concern.

We believe that the emerging NHS and care system needs strong local accountability and effective commissioners and providers working together to create integrated services. We know that local knowledge around which services a community needs, and from where they can come, is vital in unlocking the full potential of integration, particularly when engaging with the third sector. We do not want to see a return to a top-down system that imposes one-size-fits-all solutions and second guesses local decision making without fully understanding the local context and issues. The principle which should be operating is that of subsidiarity and that should be explicitly recognised by NHS England/Improvement.

3 Do these proposals undermine the principles of the foundation trust model?

These proposals risk increasing the powers of NHS England/Improvement and in the process undermining the well-developed systems of local governance and accountability that are a feature of the foundation trust model.

There is much that is positive in the model – the accountability and reach of foundation trusts into the communities they serve is one of the routes for patients and the public to have formal involvement in the running of local NHS services. Foundation trust boards often include appointed governors from local government, giving them an important opportunity to be engaged in NHS decision making. We should not throw this away.

A related risk is the erosion of the autonomy of foundation trusts when it comes to capital spending. We are not convinced that NHS England/Improvement should have the ability to set annual capital spending limits for foundation trusts in the same way it does for other trusts. We recognise the problems created when trusts break capital spending limits and some control over foundation trust capital spending may be desirable in some instances. However, in its current form, this proposal could further undermine the autonomy of foundation trusts and confuse governance and accountability arrangements. We remain to be convinced that the national bodies would be better at making investment decisions than the trust leadership that is accountable to its local board of governors.

4 What do the proposals mean for future trust mergers and acquisitions?

Most provider trust members that responded to our call for views supported the proposal to remove the Competition and Markets Authority's (CMA) role as the arbitrator for national tariff and contested license conditions. Many said that they did not think the CMA had been the right body to fulfil the functions expected of it, and they regarded the CMA as an unnecessary layer of bureaucracy, which added complexity and cost to an already difficult process.

Members told us that the CMA's strict application of competition principles, based on its experience of regulating private companies, was a poor fit for overseeing NHS transactions. Many felt that 'public interest' or 'public value' had never been at the heart of CMA decision making and they suggested that the CMA approach did not take taxpayers' interests enough into account by making sure services are provided as efficiently as possible.

CCGs also take an interest in the service configuration of the providers in their local system. They have experienced where a potential provider merger has been referred for CMA investigation. It was felt that CMA involvement was unnecessary and this may not take into account wider views on the benefits of the merger. Our members are therefore supportive of removing the CMA's powers to review mergers involving NHS foundation trusts. And whoever reviews proposals – whether NHS England/Improvement or an independent arbiter – should take into account commissioner views because of CCGs' legitimate interest and expert views about provider configuration.

Nevertheless, while trusts supported the idea of removing the CMA's role in mergers and acquisitions, some were worried that it would lead to a further concentration of power in the hands of NHS England/NHS Improvement. This was of particular concern when the plans to remove the CMA's role is combined with the proposal to give NHS England/Improvement legislative powers to direct mergers and acquisitions in specific circumstances. It is our view that mergers and acquisitions work best where they are based on strong relationships between the organisations involved and where they have been led locally in the interests of local patients.

Another concern is that, taken together with the proposal to remove the CMA's role, there is the potential for NHS England/Improvement to be both directing mergers and then judging its own decisions. We do not believe this would be appropriate and without recourse to an independent arbitrator, there is a risk that NHS trusts would be left without an appropriate route to challenge decisions around contested license conditions or national tariff levels.

5 What does the introduction of the 'best value test' mean for choice and competition?

We need to understand more clearly what replacing existing procurement duties by revoking section 75 of the Health and Social Care Act 2012 would mean, and what the implications of the proposed 'best value test' would be. For example, what criteria would be used to apply the test and how can we ensure that procurement based on the test is operating fairly, consistently and transparently. As the proposals stand, the best value test risks being too subjective and open to differing interpretations, leaving decisions open to challenge. The criteria for the test need to be clearly defined.

We accept that current practice means that too often organisations are subject to time-consuming procurement exercises which provide little or no value. Requirements to procure services by CCGs have been regarded as a barrier to successful collaborative working. CCGs have said that where a provider is performing effectively, they feel there might be negligible benefit in undertaking a time-consuming and costly procurement exercise. However, there was also recognition that procurement was a useful option to use as this could encourage innovative approaches and quality improvement from providers.

It was also noted that there is existing flexibility within the act and CCGs can adopt different approaches to procurement, but this is often based on their appetite for risk. Currently CCGs may receive conflicting legal advice about whether or not they are required to undertake procurement.

Ultimately, the ability to have more reassurance when deciding not to procure is welcome. More detail is needed on what a best value test would involve, and we look forward to further discussions about this. Members did say that this test should assess how 'reasonable' it would be to procure and what benefits it would bring.

Introducing an alternative to procurement – such as a best value test – would need to be less onerous for commissioners and providers to use and would also need to provide a mechanism for conflict resolution.

It was also recognised that removing CCGs and NHS bodies from these procurement regimes may then lead to problems with joint commissioning arrangements with local authorities. Therefore, consideration would need to be made when changing legislation to ensure that there would not be two different regimes for procurement regulation that apply to local authorities and CCGs separately.

But there is merit sometimes in testing alternative providers and the system must allow and encourage this where it is appropriate. And it is worth noting that a recent freedom of information request from the Independent Healthcare Providers Network found that services awarded by competitive tender currently make up less than 2 per cent of total CCG spending on NHS clinical services (this FOI covered the period from 2015–18).

Part of the solution could lie in agreeing a set of principles to inform procurement decisions, which we expect to be the case. These would require that decisions are transparent and designed to deliver quality and value for taxpayers and patients. Decisions should also be fair, with all types of providers (both actual and potential) treated equally and judged on their ability to integrate and deliver the best quality and value service within the budget available.

Ultimately, patients, where practicable, should continue to be able to choose from a range of different providers and there should be a mechanism by which they can seek recourse if they do not feel they have been given this opportunity.

6 What will the accountability and governance arrangements of integrated care trusts look like, and do they risk leaving community and mental health providers with a diminished voice?

As we move to more joined-up local health and care systems, it makes sense to consider new organisational forms and allow the flexibility to establish new NHS trusts that provide integrated care. However, it will be important to recognise that integrated trusts can be an enabler but that they are not the sole answer and will not always be the right answer to achieve integrated services. They should be seen as one potential vehicle for integration and for reducing governance complexity.

There will be a need to consider the accountability and governance arrangements of these entities and we recommend that they should only be established where it is clear this is the most effective way of delivering high-quality services at best value. Any decision must be in the interests of local people and the service as a whole.

In the drive to deliver more integrated care, we must avoid leaving certain areas of provision, particularly community, mental health and primary care, with a diminished voice. There is still a strong feeling that they could be overshadowed by the larger acute component within an integrated

trust and indeed within a wider integrated care system. It will be important to make sure that integration does not undermine the move towards parity of esteem for mental health and affect the ability of some providers to operate smaller scale specialised services (ie where they are delegated to local systems).

There is also a risk that integration of community, mental health and primary care services into integrated trusts could mean fragmentation of existing services. Non-acute services with strong links to each other and where positive, joint-working arrangements exist, risk being undermined and fragmented in order to fit into the new structures and arrangements.

Finally, integrated care trusts must be able to contract with local authorities too, so that they can continue to commission (either solely or in partnership) vital services.

7 Will these changes enable more joined-up commissioning?

CCGs have been commissioning collaboratively, either with other CCGs or with other commissioners, for many years. But in some cases it has been tricky to make sure they don't get stymied by the Health and Social Care Act when it comes to delegating responsibility. For instance, CCGs have largely taken on responsibility for commissioning primary medical care from NHS England but were not able to delegate this again as responsibility had already been passed onto them.

So a number of the proposals seek to resolve this, and enable more flexibility when it comes to commissioning – whether that be for primary care or other care that is currently planned and funded by NHS England, such as specialised services or services like screening, which are designated as 'Section 7A' services.

Changing legislation to allow more flexibility in commissioning responsibilities should in theory mean that fragmentation in commissioning could be reduced, as CCGs can draw together services that could be more joined up, like renal dialysis and other parts of the patient pathway. But connecting and transforming services will not be achieved just through changing the law. It will of course need the involvement of local authorities too due to their key responsibilities with many connected services, but also productive relationships and discussion with relevant providers.

8 What do the proposals mean for public accountability?

An area of weakness in the proposals is how they will promote local accountability. While foundation trusts provide a degree of local accountability through their governors and their unitary boards, this accountability could be weakened with the potential increase in powers of NHS England/ Improvement. As they stand, the proposals make no attempt to define either local or national accountability.

We are concerned that as they stand they pay little heed to the role of health and wellbeing boards, scrutiny committees and local healthwatch organisations. Any final legislative changes must create a framework that sets out clearly how the new arrangements will secure accountability at different levels and how far the centre is willing to protect the autonomy of local systems and, in turn, how they will be accountable locally.

It will be important that joint committees are transparent in the way they work, with meetings held in public and having lay members and non-executive directors a part of their governance.

9 Will the proposals increase the flexibility of national NHS payment systems?

National tariffs and activity-based payment systems, such as Payment by Results, have benefits and drawbacks. Setting fixed prices for determined activities has been used in the past as a means of making sure providers compete on quality rather than price, but this approach is inflexible and can penalise providers in high-cost areas, as well as incentivising unnecessary or inappropriate activity. The latter could undermine key aims within the NHS Long Term Plan, such as reducing outpatient appointments.

We believe there is still a need for regulated prices, but that further consideration is needed to create a system that provides flexibility to reflect specific local needs. We must also avoid unintended consequences for parts of the system, as local tariffs can present challenges over sharing the management of risk. Where providers and commissioners disagree over the appropriate level of pricing, it will be important to make sure neither side is expected to bear unreasonable levels of risk.

The proposals suggest that local prices would be set as a formula rather than a value. We need to see further detail on what the formula would include, how it would work in practice, and what the likely outcome of the chosen formula would mean for providers and commissioners. We must make sure that any changes to the national tariff does not result in a 'race to the bottom', which would affect the quality of patient care.

The data derived from the tariff can be helpful so we would want to ensure that using it, and payment by results, would still be an available option.

Our members have already been pursuing alternative ways to pay for services, and we have also seen national introduction of different options, such as the blended payment scheme for emergency care that was introduced in the 2019/20 operational planning guidance – so it's good to see these are being built on.

10 How will the leaders of front-line organisations be consulted on the proposals before they are finalised?

The proposals need to be scrutinised at every stage of their development and it will be important that the consultation process continues to be meaningful. We have been engaging with front-line provider leaders since the proposals were published, including hosting a half-day event to discuss the proposals in detail. Overall, they have been broadly positive about the direction of travel, albeit with some concerns. NHS Clinical Commissioners has similarly had ongoing conversations with CCG representatives.

They remain cautious without seeing further detail around some of the proposed changes, particularly regarding the best value test for procurement and the governance arrangements for joint committees. It is essential that front-line leaders continue to have opportunities to engage with the proposals before they are taken further.

What needs to happen next?

It is important that the process of drafting and passing legislation does not itself become an impediment to collaboration and taking forward the NHS Long Term Plan. Given the current political context and the lack of parliamentary time, it may be hard to secure these changes. As it is, they are unlikely to become law before 2022/23 at the earliest. Progress should not be held back until legislation can be passed. This must not become a reason to delay efforts to transform services.

We must also be clear how much can be done within the existing legal framework and realistic about how much change can be brought about by legislative changes alone. We have consistently heard that much of what is needed to enable greater collaboration across local health and care systems is down to behaviours, relationships, leadership and culture, none of which can be legislated for. We need national bodies and government to support NHS leaders and staff to make changes to local relationships, to bring about integration in the interest of their communities.

Written in collaboration with

NHS Clinical Commissioners
The independent collective voice of clinical commissioners

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