The NHS Long Term Plan - our view on the proposed legislative changes

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The long awaited NHS Long Term Plan has been published. The Plan builds on the principles from the NHS Five Year Forward View and sets out proposals to tackle a number of concerns, including the funding and staffing issues facing the sector, health inequalities, and growing demand for services.

There are many different aspects to comment on within the Plan, and therefore this alert is the first in a series of commentaries from DAC Beachcroft. Further alerts will follow on the impact of the Plan on various sub-sectors, including mental health, primary care, procurement and competition, commissioning, workforce, real estate and data & digital.

In this alert we focus on the requests for legislative change set out within the Plan. Whilst the legislative requests are tweaks to the current legal framework, rather than a wholesale reform of the NHS, the amendments suggested are likely to have a considerable impact if adopted. This includes matters such as an overhaul of procurement law as it applies to the health care services, as well as the abolition of the Competition and Markets Authority role in reviewing NHS statutory transactions.

Proposed Change	Our Views
Give CCGs and NHS providers shared new duties to promote the 'triple aim' of better health for everyone, better care for all patients, and sustainability, both for their local NHS system and for the wider NHS. These statutory duties on CCGs and trusts would further support them to work in tandem with their neighbours for the benefit of their local population and wider NHS. These new reciprocal duties would also contribute to supporting our wider goal of securing a stronger chain of accountability for managing public money within and between local NHS organisations.	In our experience, the tension between what is best for one organisation and its patients, and what is best for another organisation and its patients, is one of the major barriers to collaboration between healthcare providers. An overriding new duty for commissioners and providers could help surmount this barrier and overcome perceived conflicts between organisations inhibiting integration and preventing difficult decisions from being taken. For real progress there would need to be clarity about whether this duty would effectively "trump" other duties requiring officers to act in the best interests of their organisations (e.g. FT directors) or their 'own' patients, to the exclusion of others (CCGs).
Remove specific impediments to 'place-based' NHS commissioning. The 2012 Act creates some barriers to ICSs being able to consider the best way of spending the total 'NHS pound'. Lifting a number of restrictions on how CCGs can collaborate with NHS England would help, as would NHS England being able to integrate Section 7A public health functions with its core Mandate functions where beneficial.	Integrated Care Systems are made up of NHS commissioners, NHS providers and local authorities. NHS England remains the commissioner for specialised services, as well as certain public health functions. Removing some of the technical barriers to allow for place based commissioning can help foster better coordination between commissioners when planning services. In our experience good plans can flounder amid the complexity of legislation governing the sharing of functions and budgets amongst different statutory commissioners and providers. Any step that genuinely simplifies this landscape is to be welcomed.
Support the more effective running of ICSs by letting trusts and CCGs exercise functions, and make decisions, jointly. This is simpler and less expensive than creating an additional statutory tier of bureaucracy. It would mean giving NHS foundation trusts the power to create joint committees with others. It would	"Integrated Care System" is the badge for the "most evolved" form of Sustainability and Transformation Partnership. Neither STPs or ICSs have any statutory footing, and are effectively working groups with representatives from NHS commissioners, providers, and local authorities, working together as a single system despite their separate legal personalities.

allow – and encourage – the creation of a joint commissioner/provider committee in every ICS, which could operate as a transparent and publicly accountable Partnership Board. To manage conflicts of interest, any procurement decisions – including whether to procure – would be reserved to the commissioner only.

Perhaps surprisingly, there is no request for STPs/ICSs to be put on a statutory footing in the Plan (avoiding another 'statutory tier of bureaucracy'). Instead, the request is for amends to legislation to allow for joint committees for decision making amongst those organisations that are represented at STP/ICS level.

FTs cannot currently participate in joint committees at all, nor can commissioners and providers form joint committees with each other. This proposal would seek to amend that position. The ability to form joint committees is a potentially radical change for FTs because, for the first time an FT member of a joint committee can potentially be "outvoted" on decisions that affect the performance of its core healthcare functions. For this reason FTs will want to be clear that the governance of the ICS reflects a fair and effective allocation of voting rights and deals with the scope of joint decision making and any reserved matters appropriately.

Procurement decisions in order "to manage conflicts of interest" will be taken by commissioners only, but this will be in the context of a potentially more relaxed procurement regime (see later comments) if the recommendation to remove the NHS from aspects of the procurement regime is carried through. It is hard to envisage a situation where any decision by commissioners to run a tender process, or not, would not be influenced by the dynamics of the ICS Partnership Board.

At best this may mean that decisions are informed by a thorough knowledge of the strengths, capabilities and indeed weaknesses of the current providers, and a thorough understanding of the alternatives. At worst it may mean that contract decisions are unduly influenced by local politics. The Plan proposes statutory guidance for the NHS to follow to ensure best outcomes for patients and the taxpayer.

The tensions around procuring healthcare services will need to be handled with care. It could also, if not managed, result in a decrease in patient choice if (for example) voluntary sector and other independent sector providers are decommissioned as a result. These issues would need to be dealt with leaving enough real decision-making power in the hands of the new joint committee, to enable ICSs to be effective, in the absence of being placed on a statutory footing.

Support the creation of NHS integrated care trusts.

Since the repeal of NHS trust legislation in 2012, the NHS has limited options if it wants to create a new NHS integrated care provider (ICP), for example to deliver primary care and community services for the first time under a single, streamlined ICP contract. Remedying this would both reduce administration costs and help with clinical sustainability. It should also be easier for proposed organisational mergers to progress, without diluting any of the current safeguards on frontline service changes.

The Five Year Forward View included a number of acronyms, such as MCPs and PACS, and those acronyms have all been superseded and subsumed into "Integrated Care Provider". An ICP would be responsible for delivering a range of services, and it is envisaged that a population based payment would be made for the services provided under the ICP contract. The ICP model was recently tested in court in two judicial review challenges – one brought by the late Professor Stephen Hawking and others, and the other brought by a campaign group – and passed the tests on both occasions.

Organisational form has been a hurdle for NHS providers considering large scale integration projects, and this proposal should help surmount that issue for NHS providers.

Remove the counterproductive effect that general competition rules and powers can have on the integration of NHS care.

We propose to remove the Competition and Markets Authority's (CMA) duties, introduced by the 2012 Act, to intervene in NHS provider mergers, and its powers in relation to NHS pricing and NHS provider licence condition decisions. This would not affect the CMA's critical investigations work in tackling abuses and anti-competitive behaviour in health-related markets such as the supply

The NHS provider landscape is still fragmented. Despite a number of reports into different consolidated operating models for NHS providers (including the Dalton Report and NHS Five Year Forward View), provider consolidation has been limited, and in many cases, NHS mergers and acquisitions have been expensive and not always successful.

Helping NHS organisations to surmount competition law concerns should help with provider consolidation. However, the risk to

of drugs to the NHS. We propose similarly dispensing with Monitor's 2012 Act competition roles, so that it could focus fully on NHS provider development and oversight.	balance will be the potential for a detrimental effect on patient choice as a result.
Cut delays and costs of the NHS automatically having to go through procurement processes. We propose to free up NHS commissioners to decide the circumstances in which they should use procurement, subject to a 'best value' test to secure the best outcomes for patients and the taxpayer. The current rules lead to wasted procurement costs and fragmented provision, particularly across the GP/urgent care/community health service workforce. This would mean repealing the specific procurement requirements in the Health and Social Care 2012 Act. We also propose to free the NHS from wholesale inclusion in the Public Contract Regulations. We would instead set out our own statutory guidance for the NHS to follow. At the same time, we propose to protect and strengthen patient choice and control, including through our wider programme to deliver personalised care.	No doubt commissioners and providers will welcome the proposal to repeal the NHS (Procurement, Patient Choice and Competition) (No.2) Regulations 2013. The initial form of these regulations were controversial when they came into force in 2013 as they were criticised for forcing commissioners to carry out procurement processes for every health service contract. They were then quickly replaced so that commissioners were not always obliged to carry out a procurement process although they are still unclear in parts and are interpreted differently by commissioners. These regulations were based on previous NHS guidance but in the context of some healthcare services, they can be difficult to apply. The proposal to free the NHS from wholesale inclusion in the Public Contracts Regulations 2015 ("PCR") and instead provide statutory guidance for the NHS to follow, presumably relates only to the procurement of health care services as NHS organisations will still have to comply with the PCR when procuring supplies, works and other types of services covered by the PCR until the PCR are amended following the UK leaving the EU. Procuring health care services can be very complicated particularly from a point of evaluating bids and dealing with conflicts of interest. Any guidance for commissioners will need to cover whether procurement case law will still apply as the requirement to be transparent will always place onerous obligations on commissioners.
Increase flexibility in the NHS pricing regime. This would provide further flexibility in the setting of national prices, support the move away from activity-based tariffs where that makes sense, facilitate better integration of care and make it easier to commission Section 7A public health services as part of a bundle with other related services, on a nationally consistent basis.	The NHS pricing system is currently set up to reward activity in an acute setting (under the National Tariff), whereas community care and primary care services are paid for on a block and capitated basis respectively. Allowing for more flexibility in the NHS pricing regime may encourage an approach where there are more incentives to provide care in the community, where it is appropriate to do so. Although the High Court and Court of Appeal have both recently confirmed the flexibility of existing legislation covering NHS pricing, the regime is not straightforward and further clarity would no doubt be welcomed by commissioners and providers.
Make it easier for NHS England and NHS Improvement to work more closely together. We propose that as a minimum, NHS England and NHS Improvement should be free to establish a joint committee and subcommittees to exercise their functions, with corresponding streamlining of non-executive and executive functions;	Whilst NHS England and NHS Improvement have different statutory functions, there is clear merit in the two organisations working in a coordinated manner. This is not straightforward, given that NHS Improvement itself is made up of a number of statutory organisations (including Monitor and the NHS Trust Development Authority), and NHS England has a role both as a commissioner of healthcare services, as well as a quasi-regulator of CCGs. However, the recent shifts made by the two organisations towards joint working where possible have been welcomed in terms of efficiency and consistency and this change would continue that trend.

In summary, the requests for legislative change in the Plan are tweaks to the current legal framework – albeit tweaks that

will have considerable impact if adopted – rather than a request for any wholesale reform of the NHS. Given the pressures upon the NHS, stability to its structures may be welcome by most.

The rationale behind these changes appears clear and although the devil will be in the detail, we can see the benefits of all of them. The immediate question for now, is whether lawmakers will find Parliamentary time and impetus to consider and make the changes as requested.

There is a useful summary of the content of the Plan here.

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