West Yorkshire and Harrogate
Health and Care Partnership

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Dear Ian

Implementing the NHS Long Term Plan – Proposals for possible changes to legislation

I am writing in response to your engagement document *'Implementing the NHS Long Term Plan – Proposals for possible changes to legislation'.*

The Long Term Plan emphasises the important role of integrated care systems like the West Yorkshire and Harrogate Health and Care Partnership. Whilst many of our partner organisations will have submitted their own responses, reflecting the needs of their organisation and place, the Partnership felt that it was important to also submit a response on behalf of the West Yorkshire and Harrogate system.

I want to start by emphasising two points. Firstly the Partnership welcomes the approach contained in the Long Term Plan. We believe that it aligns well with our Partnership priorities and our established ways of working. We welcome the ambition to redesign services around patients and to promote collaboration. Removing unnecessary bureaucracy and promoting integrated care will make it easier for us to develop the health and care system we all need. Secondly, we have made significant progress within our Partnership under the current legislative framework. Any changes to legislation should further both the delivery of the NHS Plan and the development of our Partnership.

The Partnership welcomes the overall aim of the proposed legislative changes to prioritise integration and collaboration in the NHS. The Partnership supports many of the proposals and we would strongly suggest that their combined effect must be to create an enabling framework for local Partnerships like ours. In implementing any legislative changes we request that we are not faced with a set of overly prescriptive requirements. As with all ICSs, our Partnership has developed to meet the particular circumstances of our footprint, reflecting our principles of subsidiarity and the primacy of our places. Whilst legislative change has the potential to further support our direction of travel, we would urge caution in ensuring that there are no unintended consequences which might impede the progress that we are making. The proposals are very focused on NHS statutory organisations and it is important that they do not adversely affect non-NHS partners, such as Local Authorities, social enterprises and community interest companies, which play an important role in our Partnership.

Our concerns, and requests for clarification, are set out in the detailed response attached. On a small minority of the proposals our Partners views differ, and we have also reflected this in the detailed response.

In summary, the Partnership welcomes many of the proposals contained in the document, and the wider NHS Long Term Plan. The opportunity to promote collaboration and integration and to increasingly work as one system is one which all partners in West Yorkshire and Harrogate support.

We welcome this opportunity to respond to the proposals. Given the depth and scale of the changes, we believe that further consultation will be needed on how the feedback is addressed and is reflected in any changes to the proposals. We would welcome the opportunity to contribute to this consultation.

Yours sincerely

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Lead Chief Executive, West Yorkshire and Harrogate Health and Care Partnership
Chief Executive, South West Yorkshire Partnership NHS FT

Cc: Richard Barker, North East &Yorkshire Regional Director, NHS England and NHS Improvement
NHS Legislation Engagement Survey Mailbox
Members of the WY&H System Leadership Executive Group

Implementing the NHS Long Term Plan – Proposals for possible changes to legislation

West Yorkshire and Harrogate Health and Care Partnership - detailed comments

1. **Promoting collaboration.** This includes the following proposals:
    a. Remove the Competition and Markets Authority (CMA) function to review mergers involving NHS foundation trusts
    b. Remove NHS Improvement's competition powers and its general duty to prevent anti-competitive behaviour
    c. Remove the need for NHS Improvement to refer contested licence conditions or National Tariff provisions to the CMA

We broadly support these proposals as being in line with collaboration and place based integration.

The points on mergers suggest that these may be easier in future. Whilst mergers might be beneficial, it is important to also recognise the benefits of network developments in delivering safe and sustainable services.

The removal of duties on anti-competitive behaviours needs to be balanced with collaborative duties in the best interest of the patient. The NHS is not a market in the traditional sense and the potential reduction of competition creates a risk that large acute and specialist provider mergers could run counter to the direction of travel towards system working and a stronger interface with improved out-of-hospital models of care. A statement of the positive duties/ expectations of all NHS bodies to collaborate in the best interests of local communities would help, to make explicit what is implied by the removal of competition powers.

Further clarification would be helpful on the safeguards that will need to be in place. These might include taking into account the impact on patient choice, the views of all local commissioners and scrutiny committees and the nature of future contractual arrangements and provider business plans.

2. **Getting better value for the NHS.** This includes the following proposals:
    a. Revoke regulations made under section 75 of the Health and Social Care Act 2012 and repeal powers in primary legislation under which they are made, subject to a new best value test
    b. Remove arrangements between NHS commissioners and NHS providers from the scope of the Public Contracts Regulations, subject to a new best value test

We broadly support these proposals in reducing the burden on both providers and commissioners. They would align the law with the pragmatic approaches commonly adopted to enable collaboration and integration. In practise, the 'best value test' may not represent much of a change as commissioners regularly make judgements in relation to procurement approaches. These judgements are informed by many factors, including risk of challenge, and presumably this would still be the case. Further clarification would be helpful on:

- whether this applies to all procurements carried out by health bodies or just those relating to health services.
- the VfM tests to be applied and whether, for example, they will include Social Value as well as the usual tests
- the means of regulating the application of the best value test.
- whether in relation to the 'best value test', the reference to NHS providers is intended to be this specific? Given the role of other organisations such as not for profit

agencies, or social enterprises, we would suggest that providers of NHS services is more appropriate.

- how would the 'best value test' relate to supplies which are not covered by the current light touch regime? For example, services provided by an NHS organisation?

In addition:

(a) May have an impact on the integration of NHS and local authority commissioning. It is possible that a further loosening of formal procurement requirements in the NHS creates a bigger gap than currently exists between NHS and local government procurement practice and requirements. In order to support integrated commissioning, it might be helpful to revise the application of the PCRs to some elements of local authority commissioning (e.g. public health, social care) where joint commissioning arrangements with local NHS partners are entered into.

(b) Is broadly welcomed, but would have the effect of creating a differential position for NHS providers compared to other types of provider organisation. While this may address some concerns it may also have unintended consequences – e.g. to make it more difficult for NHS commissioners to engage with voluntary and community sector organisations. This may hinder the implementation of elements of the NHS LTP in respect of prevention and early intervention.

3. Increasing the flexibility of national NHS payment systems. This includes the following proposals:

a. Remove the power to apply to NHS Improvement to make local modifications to tariff prices, once ICSs are fully developed
b. Enable the national tariff to include prices for 'section 7A' public health services
c. Enable national prices to be set as a formula rather than a fixed value, so prices can reflect local factors
d. Enable national prices to be applied only in specified circumstances
e. Enable selected adjustments to tariff provisions to be made within a tariff period (subject to consultation)

We support the general thrust of the proposals, in particular allowing prices to be set as a formula rather than a fixed value so local factors can be better reflected in commissioning decisions. Opportunities to move away from fixed tariff arrangements will support greater provider integration and delivery of outcomes across pathways.

We also recognise that all of our acute providers are currently on aligned incentive contracts or fixed value contracts with supporting risk and reward arrangements.

Whilst we support the principles, they must not lead to too strong a focus on price and transactional elements. The acute sector has benefitted from fixed prices which have exposed issues of quality or cost and this must remain our underlying aim. Further clarity is required on how the changes will actually operate in practice including:

- how and by whom local tariffs will be set
- how the risk of anti-competitive behaviour will be mitigated
- how the proposals will relate to non-NHS providers
- whether these arrangements apply to future financial arrangements outside of the acute sector, where tariffs are not in place
- how this fix affects the development of better shared financial arrangements in each ICS.

4. **Integrating care provision.** Enable the Secretary of State to set up new NHS trusts to provide integrated care.

We welcome this proposal as it supports the integration of services for defined populations. We also welcome the role envisaged for commissioners in supporting such a change. Any new powers granted to the Secretary of State must be exercised at the invitation of the local health and care system, rather than to enable changes to be imposed without a full understanding of local circumstances and support.

The proposals may be strengthened by further clarity on ways in which social care provision could be incorporated into any such new integrated trusts. Linked to this, further progress on connecting the governance and oversight of integrated trusts with local government (Health and Wellbeing Boards etc.) would be welcomed.

Further clarification is required on:

- the nature of the "appropriate legal engagement" that will be required.
- how local commissioners should take account of provider objections.
- the role of NHSE/I in arbitration.
- the value for money tests that would be applied to the creation of new organisations rather than partnership or joint vehicles.

5. **Managing the NHS's resources better.** This includes the following proposals:
   a. Give NHS Improvement targeted powers to direct mergers involving NHS foundation trusts, in specific circumstances only, where there are clear patient benefits
   b. Give NHS Improvement powers to set annual capital spending limits for NHS foundation trusts

Partner views differ on these proposals. Some Partners are strongly opposed to the proposals (which have the potential to undermine the fundamental nature of Foundation Trusts) whilst some support them. If NHS I is given these powers, further clarity is required on the specific and exceptional circumstances in which mergers could be directed.

Other Partners support a less directive and more facilitative role for NHS I in supporting local systems. Mergers and acquisitions impact on the whole local health and care system and would need to be informed by ICS and place based discussions. In situations where local places need external support from NHS I to resolve such issues some partners would support a change of powers, but these should be seen as exceptional.

In respect of capital spending limits, it may be useful to consider the potential role of the ICS in providing guidance on capital spending proposals in the context of the collective plans of the members of the ICS.

6. **Every part of the NHS working together.** This includes the following proposals:
   a. Enable CCGs and NHS providers to create joint committees
   b. Give NHS England powers to set guidance on the formation and governance of joint committees and the decisions that could appropriately be delegated to them
   c. Allow the designated nurse and secondary care doctor appointed to CCG governing bodies to be clinicians who work for local providers
   d. Enable CCGs and NHS providers to make joint appointments

We broadly support these proposals, but with some reservations

a. Our partners have already established effective joint working arrangements at place and Partnership level. Whilst we support the ability to establish formal joint committees of CCGs and NHS providers, there are a number of questions around the practicalities of making this work. For example, the role of local authorities is not mentioned, nor is the role of other organisations such as social enterprises and the third sector. This runs the risk of creating a two tier system where only NHS bodies in our places or Partnership have a vote in a wider joint committee. An extension of these provisions to enable full participation by other partners such as local government and charitable organisations would be welcomed, as this would better reflect the intention of many place-based integrated care partnerships. Further consideration of the designation of such arrangements as being within the NHS for VAT purposes would also support integration.

b. The provision of clear guidance from NHSE regarding joint committees is cautiously welcomed. Overly specific guidance has the potential to drive unintended consequences. The guidance must enable local systems to develop the arrangements that best meet their needs.

c. Some CCGs consider that the current arrangements work adequately and do not have any particular appetite to change. However we are aware that other CCGs have difficulties in recruiting to these posts and may find this proposed change helpful.

   Whilst the proposal makes sense as a way of enabling system integration it is not entirely consistent with current NHSE advice which is that we should treat these posts in the same way as we do lay members, in particular to support the management of conflict of interest. If both the governing body practice representatives and the external clinicians are from local providers, this has the potential to mean that all clinical advice (except where it exists in management posts) could be conflicted in making clinical and financial decisions. There is definitely value to be gained from more clinical input from local providers, but this could be achieved via other means.

d. Enabling joint appointments between NHS commissioners and providers is welcomed as a freedom which is supportive of collaboration. As with some of the other proposed changes, 'workability' will be the issue and further clarity on roles and responsibilities would be helpful.

In addition to the proposals above we would note that a further area worthy of change is the double layer of governance that CCGs have with their membership and their governing body. If we place greater reliance on the use of joint committees, we perceive that the challenge of 'double governance' will become greater.

7. **Shared responsibility for the NHS.** Create a new shared duty for all NHS organisations to promote the 'triple aim' of better health for everyone, better care for all patients, and efficient use of NHS resources, both for their local system and for the wider NHS.

We are strong supporters of a system-wide approach and so the commitment that NHS bodies have shared responsibility for wider objectives in relation to population health is one we strongly support. Our NHS bodies already play a full and active role in Health and Well Being Boards and in delivering the 'triple aim' of better health, better care and efficient use of resources. This change will help to address the challenge for the Boards/Governing bodies of NHS bodies of balancing the best interests of the place, its population and the organisation. This is a significant but essential change if population health management, less competition and greater integration are to work.

Many of our organisations are moving to recognise the quadruple aim – which includes an additional requirement to deliver a sustainable workforce. We believe this is worthy of exploration in these changes.

8. **Planning our services together.** This includes the following proposals:
    a. Enable groups of CCGs to collaborate to arrange services for their combined populations
    b. Allow CCGs to carry out delegated functions, as if they were their own, to avoid the issue of 'double delegation'
    c. Enable groups of CCGs to use joint and lead commissioner arrangements to make decisions and pool funds across all their functions
    d. Enable NHS England to jointly commission with CCGs the specific services currently commissioned under the section 7A agreement, or to delegate the commissioning of these services to groups of CCGs
    e. Enable NHS England to enter into formal joint commissioning arrangements with CCGs for specialised services

We broadly support the principle of more delegation to CCGs for specialised commissioning functions. We believe that the move to New Care Models in our system on CAMHSs and Eating Disorders is already providing benefits of seeing the whole pathway through a collective understanding of resource and risk.

Any change needs to be properly managed, to ensure that there is no shifting of risk (e.g. financial or service related), without all parties being clearly sighted on the implications. Proposals to delegate further functions to CCGs also need to be tempered by a clear understanding of the considerable challenge CCGs are facing as they reduce their running costs by 20%. It is not tenable to expect additional functions to be taken on without adequate resourcing.

Further clarification is required of the rules under which NHS E can delegate section 7A service commissioning to groups of CCGs and formal joint commissioning of specialist services; and whether this is a power of NHS England or by proposal of CCGs.

9. **Joined up national leadership.** This includes the following proposals:
    a. Bring NHS England and NHS Improvement together more closely, either by combining the organisations or providing more flexibility for them to work closely together
    b. Enable wider collaboration between ALBs

We support the general thrust of the proposals, in particular closer working between NHS England and NHS Improvement. There are opportunities for a full merger to aid planning and performance in particular across systems, but there are also some concerns that the concentration of powers in a single body will have implications for local commissioners or providers who are less integrated statutorily at local level.

Further consideration will need to be given to the role of other national bodies, not least Health Education England and the Care Quality Commission.

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