The King's Fund

Ideas that change health care

Written submission

Written submission to the Health and Social Care Committee

NHS long-term plan: legislative proposals inquiry

The King's Fund is an independent charity working to improve health and care in England. We help to: shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

In line with the terms of reference for the inquiry, our response focuses on the implications of the proposals for possible changes to legislation, both individually and in aggregate. We highlight areas where further detail or clarification is required, as well as outlining our views on the key unanswered questions that these proposals raise.

Our submission draws on the following sources.

- Policy research: including our work on integrated care, place-based care, sustainability and transformation partnerships (STPs) and integrated care systems (ICSs), as well as our work on payment reform, the role of competition, patient choice, and our review of the impact of provider mergers.

- Work with the first and second wave ICSs: over the past 2 years we have provided leadership and organisational development support to ICSs, working closely with local leaders. We also published a review of progress and learning one year into their development.

- Leadership and development work with other local systems, including through our integrated care learning networks.

We welcome the inclusive approach being taken to the development of these proposals and look forward to engaging further as this progresses. This process offers an important opportunity to ensure that legislation and practice are aligned, particularly if national policy-makers continue to draw on the experience of local systems involved in implementing integrated care.

Key messages

- The King's Fund supports the spirit of the proposed changes to NHS legislation. We have long made the case that the NHS and its partners need to work differently by breaking down barriers between services to improve care for patients and give greater priority to promoting population health. This will require those working within the health and care system to collaborate across organisational boundaries.

- Progress in joining up local services has been made in spite of the current legislative framework rather than because of it. This has been achieved using workarounds, but these are inherently complex and rest on local leaders being willing to work through these complications together. If the intention is to further integrate services, then legislative changes will be needed sooner rather than later to support progress and to bring the statutory framework into line with changes to local services.

- The form and function of integrated systems is evolving locally and there is wide variation in their maturity and effectiveness. At this point, legislative changes must therefore strike a balance between providing sufficient clarity and creating enabling flexibilities without inhibiting progress by over-specifying structures. A wholesale revisiting of the legislative framework would not be desirable at present and we therefore welcome the targeted nature of these proposals.

- On the whole, the proposals take a pragmatic approach to addressing barriers to integration, and many stem directly from the experience of local systems. We would expect many of the proposed flexibilities to be helpful to advanced integrated systems looking to progress and streamline their collaborative working arrangements.

- It is important to recognise that, if enacted, the proposals would create an interim set of enabling flexibilities rather than a definitive blueprint. There is no doubt that further legislation will be needed in due course to create more coherence across the statutory framework as a whole, if a single model for NHS structures and governance is the ultimate intention.

- While we appreciate that these proposals are intended to be targeted, there are some notable omissions that we believe need to be addressed. These include clarifying the role of the Care Quality Commission (CQC) in reviewing systems as well as organisations, and how these proposals relate to the statutory role of health and wellbeing boards.

- The proposals leave significant questions about the future direction of travel for the health service. It is too early to set out the answers to all these questions in legislation, but a clearer accompanying narrative is needed to ensure a transparent and shared understanding of where the proposals are intended to lead.

- In particular, we are disappointed that the role of local government does not appear to be central to the narrative set out in the proposals or in the NHS long-term plan. In our view, the objectives of integrated care cannot be realised without the full and meaningful involvement of local government. In addition, the proposals underplay the important role of the voluntary and community sector.

- It is not clear what levers for quality and improvement the national NHS bodies intend to put in place in lieu of the system of markets and organisational autonomy that is now being unpicked. There is a risk that in the absence of other levers, these proposals reinforce greater central control over the running of local services.

- Finally, the scale and reach of these proposals should not be underestimated; they amount to a major set of changes reversing many of the principles underpinning the 2012 Health and Social Care Act and the policies that came before it. Their passage is unlikely to be straightforward and the NHS cannot put progress on hold while it waits for them to be enacted. For the time being, local systems need to continue their efforts to collaborate more closely within existing frameworks.

Supporting integration

This section relates to the following proposals:

Chapter 4 (Integrating care provision)

- Enable the Secretary of State to set up new NHS trusts to provide integrated care

Chapter 6 (Every part of the NHS working together)

- Enable CCGs and NHS providers to create joint committees
- 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
- Allow the designated nurse and secondary care doctor appointed to CCG governing bodies to be clinicians who work for local providers
- Enable CCGs and NHS providers to make joint appointments

Chapter 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

Chapter 8 (Planning our services together)

- Enable groups of CCGs to collaborate to arrange services for their combined populations
- Allow CCGs to carry out delegated functions, as if they were their own, to avoid the issue of 'double delegation'
- Enable groups of CCGs to use joint and lead commissioner arrangements to make decisions and pool funds across all their functions
- 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
- Enable NHS England to enter into formal joint commissioning arrangements with CCGs for specialised services

The case for change

The King's Fund supports the spirit of these proposals, which are intended to make it easier for local NHS bodies to work together to improve the health and care of their populations. This is in keeping with the move to create more integrated local services that has been under way for some time through the development of new care models, STPs and ICSs.

Progress in joining up local services has been made in spite of the legislative framework rather than because of it. Local systems have made use of existing flexibilities such as memorandums of understanding, joint committees and committees in common. While they can be an effective means of furthering collaboration, these workarounds are complex and bureaucratic, and often lead to duplication and protracted decision-making processes. They rest on local leaders being willing to work together and organisations giving up some of their own sovereignty, and there is nothing to prevent partners walking away or arrangements falling apart when difficult decisions arise. There are also concerns that decisions will be taken behind closed doors in forums with no statutory or public accountability (Charles *et al* 2018; Ham 2018a).

The King's Fund has long argued that if the intention (which we strongly support) is to further integrate services, then legislative changes will eventually be needed to re-establish coherence between local practice and the statutory framework. A careful balance is needed to ensure that any such changes support local developments and do not inhibit progress by over-specifying structures in legislation before it is clear how they should operate. The form and function of integrated systems is still under development and there is significant variation in the maturity and effectiveness of ICSs and STPs across the country (Charles *et al* 2018; Kershaw *et al* 2018). The King's Fund's view is that a wholesale revisiting of the legislative framework is neither achievable nor desirable at present and we therefore welcome the targeted nature of these proposals.

Integrated care systems

The proposals address many of the issues that local systems have raised as barriers to joint working. Several of the proposed flexibilities – including the ability for providers and commissioners to create joint committees, more freedom to enter into joint commissioning arrangements and addressing the issue of unlawful double delegation[1] – are likely to be helpful to advanced integrated systems looking to progress and streamline their collaborative working arrangements. However, these arrangements would remain voluntary. Under the new proposals, partners would not be compelled to participate and there remains a risk of instability in the case of disagreement. As we have highlighted previously, it is essential that development support is made available to ICSs and STPs that are further behind to avoid a situation where assistance is only available to help the best get better (Charles *et al* 2018).

Under the proposed changes, new decision-making bodies could be created through joint committees, but the responsibilities of existing organisations would remain unchanged. The risk in doing this is that lines of accountability could become increasingly unclear and confusing. When setting out the powers and duties of joint committees, careful thought needs to be given to how they will sit alongside existing organisational accountabilities. In addition, new provisions relating to the governance of joint committees will need to build in appropriate scrutiny and challenge – for example, through lay and non-executive involvement and local democratic oversight. While we support the aims of the proposed new duty to collaborate, it is unclear how this 'shared duty' will operate in practice and what it will add beyond existing duties.

Overall, these proposals create an interim set of enabling flexibilities rather than an end-state model. Even if they are enacted, further legislation will be needed in due course to appropriately reflect the growing role of ICSs, through formal statutory powers and accountabilities.

Specialised commissioning

We are aware that the Health and Social Care Committee has raised questions over the proposal for NHS England and CCGs to be able to enter into joint commissioning arrangements for specialised services and whether this could affect patient access. The specialised commissioning budget has grown significantly in recent years and now stands at more than £17 billion. A wide range of services sit within this. For some of these, particularly those that are highly specialised, there is a clear case for them to be commissioned across large areas. For services that are less specialised and form parts of pathways of care covered by other commissioning budgets, it may be desirable for local systems to have greater input into decisions to make the best use of resources and deliver joined-up services. As part of making these changes, NHS England will need to outline what services will be commissioned at these different levels in the future.

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[1] Under current arrangements, once NHS England has delegated a function to a CCG, that CCG cannot enter into formal joint decision-making arrangements for that function with neighbouring CCGs or local government as this would constitute unlawful 'double delegation'.

Contractual routes to integration

Under the proposals, the Secretary of State for Health and Social Care would be given powers to set up new NHS trusts to deliver integrated care. Much more clarity is needed around the purpose, functions and governance of this new type of NHS trust. In the absence of this clarity, it is difficult for us to assess this proposal. If it is taken forward, close scrutiny will be required to ensure that appropriate governance and accountability arrangements are in place.

Depending on the detail, this could in theory be a helpful option for areas wishing to use a contractual route to integrate services under the integrated care provider (ICP) contract (if and when this is made available) by creating a suitable, publicly accountable NHS organisational form to hold the contract. This supports the expectation in the NHS long-term plan that ICP contracts would be held by public bodies and, alongside suggested changes to procurement requirements, may help assuage concerns that the contract could lead to a greater role for the private sector in providing services. However, our understanding is that only one area (Dudley) is actively pursuing this route at present, so we would not expect this to be widely used, at least in the short term. Furthermore, questions remain over whether new contractual vehicles are necessary or desirable as a route to integrating care (Ham 2018b). There is growing interest in shifting away from arm's length contracting and complex incentive schemes to concentrate on building effective partnerships and collective responsibility for making the best use of resources (Collins 2019).

The role of local government

Health and wellbeing boards are almost entirely absent from the proposals despite their statutory role and potential overlap with the proposed new joint committees. Their current and future role needs to be clarified.

The proposals focus on integration within the NHS and take insufficient account of the need for collaboration between the NHS and local government. Alongside the continued delay to the Green Paper on social care, this is a missed opportunity to take a coherent approach to the issues facing health and care and to reach the sustainable settlement that is so urgently needed (Bottery *et al* 2018; Commission on the Future of Health and Social Care in England 2014).

This is an area where national NHS bodies could be clearer about the broader intended direction of travel. If the government and national NHS bodies are serious about the ambition to integrate care around the needs of individuals, then they must recognise that local government are essential partners in making this happen (Charles *et al* 2018). It is disappointing that local government's role does not appear to be central to the narrative set out in the proposals or in the NHS long-term plan (Charles *et al* 2019).

Competition and procurement

This section relates to the following proposals:

Chapter 1 (Promoting collaboration)

- Remove the Competition and Markets Authority (CMA) function to review mergers involving NHS foundation trusts
- Remove NHS Improvement's competition powers and its general duty to prevent anti-competitive behaviour
- Remove the need for NHS Improvement to refer contested licence conditions or National Tariff provisions to the CMA

Chapter 2 (Getting better value for the NHS)

- 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
- Remove arrangements between NHS commissioners and NHS providers from the scope of the Public Contracts Regulations, subject to a new best value test

Chapter 5 (Managing the NHS's resources better)

- Give NHS Improvement targeted powers to direct mergers involving NHS foundation trusts, in specific circumstances only, where there are clear patient benefits

NB: The proposal in Chapter 5 related to capital spending limits is discussed in the section on ***Payment systems and capital***.

Overview

In recent years, the NHS has been moving away from choice and competition towards cooperation and collaboration, despite a legislative framework that seeks to promote the former. These proposals would reduce the pretence that competition is a major lever in the system for NHS bodies.

Evidence for the benefits of competition in health care is both equivocal and contested, and where benefits exist these may be offset by the considerable transaction costs involved in contract negotiations and regulatory intervention (Ham 2013; Mays 2011). However, competitive procurement will continue to be appropriate in some cases – for example, where the NHS needs to bring in new capacity or innovative service models – and arrangements will therefore need to ensure that commissioners can continue to draw on the skills and contribution of both the voluntary and independent sectors in future.

While research has found that choice of provider has not acted as a particularly strong driver for service improvement, it is valued by patients and remains enshrined as a patient right in the NHS Constitution (Department of Health 2015; Dixon et al 2010). Our understanding is that these proposals do not spell out the end of patient choice in the NHS. Rather, the power to set standing rules in primary legislation will be explicitly amended to require inclusion of patient choice rights and, as set out in the NHS long-term plan (NHS England 2019), that choice and control will be further strengthened as part of

the wider personalisation agenda – for example, through the rollout of personal health budgets.

Proposals relating to competition duties

In reality, the role of competition has already been significantly reduced in the NHS. A competitive market cannot truly exist where there is insufficient capacity in the system and a growing number of providers are propped up by national bodies. In addition, there has been a focus on increasing collaboration between providers and commissioners as advocated in the *NHS five year forward view,* currently being driven through ICSs and the development of new care models.

Given this reality, we broadly agree with the proposals to remove NHS Improvement's competition powers and duties as well as the CMA's function to review mergers involving NHS foundation trusts. The CMA itself has highlighted the incongruity of merger controls to protect competition in a sector where competition has little role to play and have only ruled against one merger in practice (Dunhill 2017).

Proposals relating to procurement

We welcome the proposals to reduce tendering requirements in the NHS. Current requirements pit providers and commissioners against each other in transactional relationships rather than encouraging them to work together to make best use of their collective resources.

The extent to which existing requirements to tender represent an actual or perceived barrier is not clear (we believe commissioners could be doing it less than they currently do); but regardless of this, there remains confusion among commissioners, and changes to the legislation could help to clarify this. For example, to deliver better care, providers often need to group together in ways that restrict competition by entering alliances to develop more integrated services or dividing up responsibilities as part of a network. Although this can be done within existing legislation, organisations wishing to do so often find themselves having to navigate a legal minefield simply to determine what is permissible (Collins 2015b).

Further, the recent experience of the Dudley Multispecialty Community Provider (Dudley CCG n.d.) highlights some of the drawbacks of being forced down a procurement route, including time and transaction costs and the impact on local relationships (for more detail, *see* Battye *et al* 2017).

The proposals lift this barrier, thereby addressing one of the key areas that prevents local systems from progressing new models of care (Ham *et al* 2016).

Our understanding is that these proposals do not spell the end of competitive procurement in the NHS. However, much of the detail around how this will operate in future has been left to the development of a new 'best value' test. Commissioners should retain the ability to tender where they think it makes sense to do so. Without the detail, the full implications of these proposals are difficult for us to judge. Adequate scrutiny of this new

test will be required once more information is made available. However, in the absence of this detail, our initial thoughts are as follows.

- There are some fundamental questions about how this test would work. For example, what would be required for a commissioner to demonstrate that they were obtaining best value by continuing to work with a particular provider rather than competitively tendering? If the criteria are unclear, commissioners could devote considerable time and resource in trying to demonstrate this.

- There is also a major question about what would be taken into account when assessing 'value'. Clearly, it is important that this does not focus on cost at the expense of quality. Ideally, 'value' would be linked to outcomes, but in practice, we know it is extremely difficult to define and measure high-level outcomes for complex groups of health and care services. There is then also a question about whether different criteria would be needed for different types of services.

- A key consideration will be how this test can be designed in a way that ensures that the skills and contributions of the voluntary and community and independent sectors are harnessed where appropriate, and that appropriate safeguards are in place to deter unhealthy monopolistic behaviour.

While these questions will need to be answered, it will be important to avoid making the best value test more onerous than going out to tender. The complexity of the test, and the scope for legal challenge against commissioners' use of it, may determine whether it provides flexibility or just creates more bureaucracy. Under a poorly constructed test, commissioners may cover themselves against challenge by routinely going out to tender. It is worth remembering that under the current procurement rules, commissioners are free to determine whether it is necessary to tender in the interests of their patients. Simply changing the rules may not get to the heart of the issue.

Proposals relating to mergers

As currently drafted, the proposal to give NHS Improvement targeted powers to direct mergers or acquisitions involving NHS foundation trusts 'in specific circumstances only' leaves it unclear as to when and in what scenario national NHS bodies would use this power. We would be concerned about any powers that are too broad, leaving them open to misuse.

Evidence highlights that the impact of mergers is at best mixed and mostly disappointing, failing to deliver the intended benefits. Our review of 20 mergers between 2010 and 2015 highlighted the significant time, costs and risks involved, concluding that national bodies should focus on supporting service improvement and transformation where possible, rather than instigate a merger (Collins 2015a). We would therefore urge caution over mergers being seen as a default solution. Careful assessment of the costs, risks and likely benefits should be undertaken in every case. Any power to direct mergers should be very specific and used only in exceptional circumstances.

In addition, this proposal should be read alongside the proposal to remove the CMA's powers to review mergers (with this function continuing to reside with NHS Improvement). Taken together, these powers could leave local organisations with little ability to challenge any instruction from NHS Improvement to merge, should they disagree with it.

Finally, alongside proposals to limit foundation trust capital spending (*see* below), the decision to give NHS Improvement the powers to direct mergers or acquisitions involving NHS foundation trusts weakens any remaining autonomy associated with being a foundation trust. Although foundation trusts have, in practice, lost much of their operational freedoms as money has become tight, it raises the question of whether the foundation trust model is something the NHS should try to hold on to, or whether – in a world where organisations are increasingly working collectively in local systems – it is past its sell-by date. This is an area where national NHS bodies will need to be clearer about the broader intended direction of travel, sooner rather than later.

Payment systems and capital

This section relates to the following proposals:

Chapter 3 (Increasing the flexibility of national NHS payment systems)

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

Chapter 5 (Managing the NHS's resources better)

- Give NHS Improvement powers to set annual capital spending limits for NHS foundation trusts

NB: The proposal in chapter 5 related to mergers is discussed in the section on **Competition and procurement**.

The King's Fund welcomes the goal of a payment and incentives system that supports better collaboration between commissioners and providers of NHS care, and the more efficient use of resources. However, we question whether these proposals go far enough, particularly in the context of the substantial changes that have been made in recent years in the absence of legislation, including through the introduction of control totals, the Sustainability and Transformation Fund, provider and commissioner sustainability funds, and the widespread use of loans to cover deficits.

On the specific proposals, insufficient detail has been provided in the consultation document to assess whether these changes are needed, what their impact will be, and how they fit with previously stated ambitions (Dalton 2018) to review the financial architecture of the NHS.

Several proposals relate to the National Tariff Payment System ('the tariff'). This includes a proposal to set national prices under the tariff as a formula rather than as a fixed value. It is hard to provide comment without further information on the details of the formula and how it will be applied. Under the local variation process set out in the current legislation, commissioners and providers already have the flexibility to agree local tariff adjustments; a clearer explanation is needed on why the existing processes are insufficient. It is also unclear whether this additional flexibility would lead to some local systems spending disproportionate time in negotiating the price of delivering care, rather than the quality and volume of care. National NHS bodies need to provide assurances and implement safeguards against the possibility of this inadvertently leading to price competition for clinical services.

The theme of local decision-making and flexibility runs through the proposals around the tariff, albeit inconsistently. Some proposals bring services under a national pricing regime (such as public health services commissioned under section 7A of the NHS Act 2006), while other proposals increase local flexibility in using national prices. Proposals to move responsibility from NHS Improvement to ICSs for local modifications – where national tariff prices are adjusted to reflect structural issues that make the costs of services uneconomic in a local area – must be more carefully considered. It is unclear whether ICSs are the right mechanism through which to pool financial risk where services are economically unviable.

On capital spending controls, there are two related issues. The first and most pressing issue is the limited amount of funding available rather than how it is spent – in part a consequence of financial management decisions by national NHS bodies to move capital funding to support day-to-day NHS spending (National Audit Office 2019). Second, while there is an argument for aligning management of foundation trust and trust finances, it is unclear whether this additional national management will be effectively used to deliver more sustainable and effective capital investment (Healthcare Financial Management Association 2018). If greater powers over foundation trust capital spending were introduced, there would certainly need to be further assurances to ensure that these were used appropriately.

This proposal seems to be intended to address inequity between the availability of capital for NHS trusts and foundation trusts. While it is clearly important to ensure that the allocation of capital is fair, the more significant concern is the overall sum available. Implicit in this proposal is a risk that it could inadvertently create a route for national NHS bodies or government to drive down overall capital spending. This proposal also further weakens the remaining autonomy associated with being a foundation trust, as mentioned previously in relation to the proposals regarding mergers.

It is not clear that these proposals get to the heart of the issue. Greater clarity, coherency and strategic intent is needed on how NHS finances will be managed in the future, and the role of the payment system and legislation in supporting this.

Overall, The King's Fund would also like to note that we are sceptical about the reliance on financial levers and development of new complex payment systems to manage the performance of providers. The evidence so far is that these schemes are costly to develop, distract leaders from other priorities, and often fail to deliver the intended benefits. Our recent report on payment systems for integrated care advocated the development of simple payment schemes that allow local leaders to move resources to those parts of local systems that need them most, to reduce the amount of time local leaders spend on negotiating payments, and support system-wide collaboration on improvement (Collins 2019).

The relationship between national bodies and local systems

This section relates to the following proposals:

Chapter 9 (Joined-up national leadership)

- Bring NHS England and NHS Improvement together more closely, either by combining the organisations or providing more flexibility for them to work closely together
- Enable wider collaboration between arm's length bodies (ALBs) by establishing new powers for the Secretary of State to transfer, or require delegation of, ALB functions to other ALBs, and create new functions of ALBs

Efforts are already under way to bring NHS England and NHS Improvement together. This includes the recent creation of joint regional teams and the appointment of a single chief executive. The national NHS bodies are now proposing to take this further, either through a full merger or by additional powers being granted that allow the two organisations to act jointly or transfer functions between them. It is also suggested that the national bodies' accountability to the Secretary of State and Parliament will be clarified. It is difficult for us to assess this as no further detail is provided on the intention behind the statement or what it is expected to involve.

It has been clear for some time that greater coordination and consistency is needed between NHS England and NHS Improvement; our work with the first 10 ICSs found that regulation continues to focus on the performance of organisations rather than systems and that local leaders often receive conflicting messages from national NHS bodies, particularly at the regional level (Charles *et al* 2018). The CQC's local system reviews highlighted the 'significant role' of regulators in driving behaviours that run counter to collaboration (Care Quality Commission 2018). The King's Fund welcomes efforts to align the approach of the regulators to support local collaboration. However, we would also emphasise that behaviours and cultures within the national bodies – in particular, the way that the regional teams interact with local systems – will be a more important enabler than structural organisational change (National Improvement and Leadership Development Board 2016).

The proposals suggest that new powers should be established to allow the Secretary of State to transfer or require delegation of functions between arm's length bodies and to create new functions. It is not at all clear why and for what purpose this is being

suggested. We are puzzled as to the motivation behind this proposal and – in the absence of further information – we are concerned that this could be very broad and have far-reaching implications, including reduced autonomy for NHS arm's length bodies and greater scope for political intervention in the NHS. Our view is that much more detail is required to understand the intention behind this new power; when and how it might be used must be set out clearly in legislation.

The ability to transfer or delegate functions between arm's length bodies would mean that a newly merged NHS England/NHS Improvement could then acquire additional powers that currently lie elsewhere. Examples of areas where this is suggested as having potential benefits include prevention of ill health, and workforce education and training, indicating that Public Health England and Health Education England may be among the bodies involved. This could, in theory, lead to the creation of one very large national body with wide-reaching powers. Regional teams operating as outposts of NHS England/NHS Improvement would hold significant power over ICSs (particularly for as long as they continue to be non-statutory bodies with unclear responsibilities and freedoms), and there is a major risk that this could open the door to greater central intervention in the running of local health systems, cutting across the principle of subsidiarity. The scope for centralisation of power is further increased by the proposals for national NHS bodies to be able to direct mergers and acquisitions and set capital expenditure limits for foundation trusts.

The fundamental question which is not addressed in these proposals is what the appropriate relationship should be between central government and local systems. Which decisions should be made nationally and which made locally? How will the freedom and autonomy of local systems be protected? And what division of responsibilities and model of governance do the national NHS bodies intend to put in place in lieu of the system of regulators, markets and organisational autonomy?

Reflections

What is missing

While we appreciate that these proposals are intended to be targeted, there are several notable omissions that we believe need to be addressed. These include the role and powers of the CQC in regulating health systems as well as organisations, and how these proposals relate to the statutory role of health and wellbeing boards. Indeed, the CQC itself has argued that the regulatory framework should be improved so that it has the power to look at the quality of care across a system, as well as in the individual organisations that provide health and social care services (Care Quality Commission 2018).

We understand that further detail will be provided in relation to some areas, including, for example, the best value test and the governance framework for ICS joint committees. This will be necessary to enable a proper assessment of the implications of these proposals.

Finally, some of the proposals introduce additional powers and flexibilities – for example, the proposal to give NHS Improvement 'targeted powers' to direct mergers or acquisitions involving NHS foundation trusts, and the proposal to give NHS Improvement powers to set annual capital spending limits for NHS foundation trusts. As already noted, there is insufficient detail about how and in what circumstances these powers will be used, which makes it difficult to assess whether the proposals will have unintended consequences or be open to misuse.

The bigger picture

Although they are framed as targeted proposals and, in many cases, simply align the statutory framework with the workarounds already taking place, together these add up to a significant package of changes that unpick some of the principles on which the 2012 Health and Social Care Act was built.

The proposals leave some significant unanswered questions about the future direction of travel for the health service, for example: what the vision is for the future financial architecture; how lines of accountability for ICSs will work alongside the new regional offices of NHS England/NHS Improvement; how the risk of monopolistic behaviour will be managed; and many other issues besides.

It would not be appropriate to attempt to set out all the answers to these questions in legislation. Indeed, the experience of the 2012 Act underlines the case for avoiding over-specifying a theoretical end state. But the proposals need to be supported by an overarching narrative to set out the direction of travel and ensure that there is a transparent and shared understanding of where they are intended to lead.

For example, while the proposals explicitly diminish the role of competition and organisational autonomy as drivers for improvement, they do not address the question of what will replace them. In reality, central bodies have relied far more on national intervention and performance management as a lever for managing the health system in recent years. There is a risk that the proposals could open the door to even greater central control over the running of local services, but it is not clear whether this is the intention.

There is also a need for a clearer supporting narrative around the ambition for integration across the NHS and local government. In our view, the objectives of integrated care cannot be realised without the full and meaningful involvement of local government and we are therefore disappointed that their role does not appear to be central to the narrative set out in the proposals or in the NHS long-term plan.

What next?

It is important to recognise the limitations of what legislative change can achieve. It is not possible to legislate for collaboration and coordination of local services. This requires changes to the behaviours, attitudes and relationships of staff and leaders right across the health and care system, including within the national NHS bodies.

Because these proposals are potentially far-reaching, we do not expect their passage to be straightforward. The NHS cannot put progress on hold while it waits for them to be enacted. For the time being, local systems need to continue their efforts to collaborate more closely within existing frameworks and to guard against the distraction of legislation slowing down improvements to local services.

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