



House of Commons
Health and Social Care
Committee

**NHS Long-term Plan:
legislative proposals**

Fifteenth Report of Session 2017–19

*Report, together with formal minutes relating
to the report*

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Health and Social Care Committee

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Contacts

All correspondence should be addressed to the Clerk of the Health and Social Care Committee, House of Commons, London SW1A 0AA.

The telephonenumber for general enquiries is 020 7219 6182; the Committee's email address is hscocom@parliament.uk.

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Summary

In 2018, we recommended that the law needed to change to fully realise the move to a more integrated, collaborative and place-based approach to health and care. We were pleased that the Prime Minister acknowledged this and then asked NHS England and NHS Improvement to make proposals for legislative change.

The current legislation was designed to encourage choice and competition in the NHS, rather than collaboration. Since the NHS Five Year Forward View, the NHS has had to use workarounds to overcome barriers posed by the legislation. To avoid the mistakes of previous reforms, we recommended that the health and social care community should lead the development of proposals for legislative change.

NHS England and NHS Improvement's proposals are broadly welcome. They are a pragmatic set of reforms, which remove barriers to integrated care. This evolutionary and consultative approach to health reform is welcome, particularly given the challenge of legislating in a hung Parliament and the fact that there remains little appetite for another large-scale top-down reorganisation of the NHS.

The proposals, we heard, are nevertheless too NHS-centric, with too little consideration for the wider system with which the NHS seeks to integrate. The Department of Health and Social Care, NHS England and NHS Improvement should be clearer about the input and roles local government, the voluntary and wider community sector, as well as independent providers, are expected to have in the future of the NHS.

Choice and competition

We warmly welcome the intention behind the proposals to promote collaboration and lessen the role of competition in the NHS, especially the proposal to repeal section 75 of the Health and Social Care Act 2012 and revoke the regulations made under it. Competition rules add costs and complexities, without corresponding benefits for patients and taxpayers in return. Choice and competition can help raise standards and encourage innovation, but, as an organising principle, collaboration is a better way to manage the rising demands on health and social care, improve joined up care for patients and deliver better value for taxpayers. This does not mean however that the NHS should become a monopoly.

The Department of Health and Social Care, NHS England, NHS Improvement and the NHS Assembly should co-produce a 'best value' test, underpinned by a broad definition of value. The quality of care and health outcomes should be at its heart, but it should also be aligned with the underlying concepts of wider public and social value used by other public services. The term 'best value' itself is perceived in local government to be synonymous with cost-cutting, so we recommend it should be replaced because it is the principle that is most important.

Integrated care provision

The law should rule out the prospect of non-statutory providers holding an Integrated Care Provider contract. Until the law is changed, we strongly urge that any ICP contract should be held by an NHS body.

We support the proposal to give the Secretary of State powers to create new NHS trusts. This will help commissioners who struggle to find a suitable provider to hold an ICP contract. The decision to create a new NHS trust must have local buy-in and represent the most effective use of local resources. This power must not be used by the Department or national bodies to impose a form of integration on local health and care services or as threat to force organisations to collaborate.

Integrated care systems

Now is not the right time to establish integrated care systems as separate legal entities because that would require far more extensive legal changes. However, we are concerned about the governance and accountability of ICSs. All STPs and ICSs should meet the highest standards of openness and transparency in the conduct of their affairs by holding meetings in public and publishing board papers and minutes. Transparency is not as good as formal accountability, but to avoid another top-down reorganisation of the NHS, we believe it is the most pragmatic way forward.

Proposals to improve system working, such as the formation of joint committees are too NHS-centric. The law should enable local authorities to participate in joint committees with providers and clinical commissioning groups. The proposed “triple aim” of better health for everyone, better care for all patients and efficient use of NHS resources should be rephrased to include a specific reference to wellbeing.

National bodies

More detail is needed on how giving the Secretary of State powers to transfer, or require the delegation of, functions from one arm’s-length body to another will improve joined up care and value for patients. The strategic intent behind this proposal is unclear.

The NHS at a national level must continue to support, encourage and empower local leadership. We do not support the proposals, in their current form, to give NHS Improvement the ability to direct foundation trust mergers, acquisitions and capital spending limits. While we support, in principle, the proposal for NHS England and NHS Improvement to merge, we are concerned about the degree of central control that could result from this merger, especially in light of the other changes put forward. We would like to see more detail on how unintended consequences of this merger will be avoided.

When these proposals come before us again as a draft bill, one of the issues we will want to consider very carefully is how local autonomy will be protected under the new arrangements.

Introduction

Our inquiry

Our previous inquiry into 'Integrated care: organisations, partnerships and systems'

1. In June 2018, we published a report following our inquiry into 'Integrated care: organisations, partnerships and systems.'¹ We concluded that while positive progress towards collaborative working and integrated care had been made within the constraints of the current legislative framework, this required cumbersome workarounds, and led to local areas operating with significant risks in terms of their governance and decision-making. We concluded that ultimately “the law will need to change to fully realise the move to more integrated, collaborative, place-based care.”²

2. In coming to this view, we were clear that “the purpose of legislative change should be to address problems which have been identified at a local level which act as barriers to integration in the best interest of patients”.³

3. We also heard during that inquiry that repeated top-down reorganisation of the health service, including the changes made by the Health and Social Care Act 2012, meant there was little appetite from local leaders of health and social care services for major legislative reform. We therefore recommended that the Department of Health and Social Care and national bodies should adopt an evolutionary, transparent and consultative approach to determining the future shape of health and care, with proposals being led by the health and care community. We further recommended that Parliamentarians across the political spectrum should work together to support the legislative changes to facilitate evolutionary change in the best interests of those who rely on these services.

The response

4. The NHS Long Term Plan was published on 7 January 2019.⁴ In setting out a blueprint for the development of the NHS over the next decade, the Plan made clear that changes to the law were not required for the plan to be implemented. However, it stressed that “amendment to the primary legislation would significantly accelerate progress on service integration, on administrative efficiency, and on public accountability.”⁵ The legislative proposals put forward were a direct response to the formal request from this Committee and from the Prime Minister and were developed by NHS England in discussion with NHS colleagues, based on the views of clinicians and NHS leaders, as well as national professional and representative bodies.⁶

5. The provisional list of proposed legislative changes in the Long-Term Plan were developed and published for consultation by NHS England and NHS Improvement in

1 Health and Social Care Committee, [Integrated care: organisations, partnerships and systems](#), Seventh report of Session 2017–19, HC 650

2 Ibid, paras 295 and 296

3 Ibid, Para 299

4 NHS England, [The NHS Long Term Plan](#), January 2019

5 NHS England, [The NHS Long Term Plan](#), January 2019

6 NHS England, [The NHS Long Term Plan](#), January 2019

February 2019 in the document ‘Implementing the NHS Long Term Plan: Proposals for possible changes to legislation’.⁷ Nine groups of suggested legislative changes were set out in further detail with requests for responses to a short survey or more detailed feedback by 25 April 2019. The proposals are set out in Table 1 below. In response NHS England and NHS Improvement received:

- 85 email responses;
- 624 responses via Citizenspace;
- 8,543 responses from a Section 75 campaign email;
- 9,807 responses from a workforce campaign email; and
- 173,750 campaign standard responses from 38 Degrees.

NHS England and NHS Improvement have shared the vast majority of the written responses with us as well as key findings from the quantitative responses they received via Citizenspace. We are grateful to have had access to this extra source of evidence for our own inquiry.

Our inquiry

6. We launched our inquiry into the ‘NHS Long Term Plan: legislative proposals’ with a call for written evidence on 1 March 2019. The first phase of this inquiry is focused on the proposals published by NHS England and NHS Improvement, particularly in light of our view that the legislation should be designed expressly to remove barriers to integrated care in the interests of patients and should be led by the health and care community. In scrutinising the legislative proposals put forward to support the implementation of the NHS Long Term Plan we aim to assess the proposals from a cross-party Parliamentary perspective and set out views which we intend should be helpful in working them up into a draft bill. When such a draft bill is, in due course, laid before Parliament, we plan to carry out the second phase of this inquiry, conducting more detailed pre-legislative scrutiny of the proposals.

7. We received just under 60 written submissions providing a rich body of evidence which has informed this report and the questions we put to those who gave oral evidence to the committee. We held four oral evidence sessions, during which we heard from stakeholders across the health and care community, including campaign groups, professional bodies and trade unions, representatives of NHS bodies including commissioners and providers and those with experience of delivering integrated care, lawyers, academics, think tanks and representatives of staff and patients.

7 NHS England and NHS Improvement, [Implementing the NHS Long Term Plan: Proposals for possible changes to legislation](#), March 2019

8. We are very grateful to all those who gave written and oral evidence to us. We are also grateful to our two specialist advisers, Professor Pauline Allen of the London School of Hygiene and Tropical Medicine and Nicholas Timmins, Senior Fellow at The King's Fund, for their advice and guidance throughout our inquiry.⁸

Table 1: NHS England and NHS Improvement's legislative proposals

Category	Proposed changes
Promoting collaboration	<p>NHS England and NHS Improvement propose that:</p> <ul style="list-style-type: none"> • the CMA's function to review mergers involving NHS foundation trusts should be removed; • NHS Improvement's competition powers and duties should be removed; and that • the need for NHS Improvement to refer contested licence conditions or National Tariff provisions to the CMA should be removed.
Getting better value for the NHS	<p>NHS England and NHS Improvement propose that:</p> <ul style="list-style-type: none"> • the regulations made under section 75 of the Health and Social Care Act 2012 should be revoked and the powers in primary legislation under which they are made should be repealed and replaced by a best value test; and • arrangements between NHS commissioners and NHS providers are effectively removed from the scope of the Public Contracts Regulations and that NHS commissioners are instead subject to a new 'best value' test when making such arrangements, supported by statutory guidance.

8 Professor Pauline Allen holds a series of research grants from the Policy Research Programme of the NIHR. The following research concerns issues of relevance to the inquiry: 1. Evaluation of New Models of Care Programme: Professor Katherine Checkland and Professor Matt Sutton of Manchester University (Principal Investigators) in which she is a co-investigator.
2. National Policy Research Unit in Health and Social Care Systems and Commissioning: Professor Stephen Peckham of Kent University is director. Professor Allen is co director with Professor Kath Checkland.
Nick Timmins, Senior Fellow, The King's Fund. Mr Timmins' Pecuniary interests is that he is retained by the King's Fund two days a week, and undertakes work for others, chiefly think tanks, with some occasional journalism, on a case by case basis. He is also an honorary fellow of the Royal College of Physicians..

Category	Proposed changes
Increasing the flexibility of national NHS payment systems	<p>NHS England and NHS Improvement propose that legislation should:</p> <ul style="list-style-type: none"> • allow national prices to be set as a formula rather than a fixed value, so that the price payable can reflect local factors; • provide a power for national prices to be applied only in specified circumstances, for example allowing national prices for acute care to cover ‘out of area’ treatments but enabling local commissioners and providers to agree appropriate payment arrangements for services that patients receive from their main local hospital in accordance with tariff rules; • allow adjustments to provisions within the tariff to be made (subject to consultation) within a tariff period, for example to reflect a new treatment, rather than having to consult on a new tariff in its entirety for even a minor proposed change. <p>NHS England and NHS Improvement also propose that:</p> <ul style="list-style-type: none"> • once ICSs are fully developed, the power to apply to NHS Improvement to make local modifications to tariff prices should be removed; and • primary legislation should be changed so that the national tariff can include prices for ‘section 7A’ public health services.
Integrating care provision	<p>NHS England and NHS Improvement propose that:</p> <ul style="list-style-type: none"> • the law should be clarified so that the Secretary of State can set up new NHS trusts to deliver integrated care across a given area.
Managing resources better	<p>NHS England and NHS Improvement propose that:</p> <ul style="list-style-type: none"> • NHS Improvement should have targeted powers to direct mergers or acquisitions involving NHS foundation trusts, in specific circumstances only, where there are clear patient benefits; and • NHS Improvement should have powers to set annual capital spending limits for NHS foundation trusts, in the same way that it can currently do for NHS trusts.

Category	Proposed changes
Every part of the NHS working together	<p>NHS England and NHS Improvement propose that:</p> <ul style="list-style-type: none"> • organisations [CCGs and NHS trusts and foundation trusts] should be given the ability to create joint committees; • there should be new provisions relating to the formation and governance of these joint committees and the decisions that could appropriately be delegated to them; • restrictions should be removed so as to allow the designated nurse and secondary care doctor appointed to CCG governing bodies to be clinicians who work for local providers; and • express provision should be made in legislation to enable CCGs and NHS providers to make joint appointments.
Shared responsibility for the NHS	<p>NHS England and NHS Improvement propose that:</p> <ul style="list-style-type: none"> • a new shared duty should be introduced that requires those organisations that plan services in a local area (CCGs) and NHS providers of care 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.
Planning our services together	<p>NHS England and NHS Improvement propose that:</p> <ul style="list-style-type: none"> • NHS England should be given the ability to allow groups of CCGs to collaborate to arrange services for their combined populations. We also propose that CCGs should be able to carry out delegated functions, as if they were their own, to avoid the issue of ‘double delegation’, and that groups of CCGs should be able to use joint and lead commissioner arrangements to make decisions and pool funds across all their functions; • provisions are made to 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; and • that legislation is changed to enable NHS England to enter into formal joint commissioning arrangements with CCGs.

Category	Proposed changes
Joined up leadership	<p>NHS England and NHS Improvement propose that both organisations should be brought together more closely beyond the limits of the current legislation, whilst clarifying the accountability to Secretary of State and Parliament, by either:</p> <ul style="list-style-type: none"> • creating a single organisation which combines all the relevant functions of NHS England and NHS Improvement (including Monitor and the TDA); or by • leaving the existing bodies as they are, but provide more flexibility to work together, including powers to carry out functions jointly or to delegate or transfer functions to each other, and the flexibility to have non-executive Board members in common.

Source: NHS England and NHS Improvement, [Implementing the NHS Long Term Plan: Proposals for possible changes to legislation](#), March 2019

1 Proposals for legislative change: main findings

9. In our report on integrated care last year, we acknowledged that the law needed to be amended to support the goal of greater integration of health and care. The Health and Social Care Act 2012 is lodged in the minds of those working in the NHS and the wider health and social care system as well as Parliamentarians as a reminder of the destabilising dangers of wholesale system churn. Given those dangers as well as the reality of a hung Parliament, we were of the view that, in keeping with the principles outlined within the NHS Five Year Forward View, legislative change should be carried out in an evolutionary and consultative way, with a focus on removing legal barriers that stop, or impede, those working in health and social care from collaborating and integrating services around their patients. We heard that broadly speaking NHS England and NHS Improvement's proposals are a pragmatic set of changes that have the potential to help reduce some of the barriers to joint working for those on the front line of health and care in England. They are limited in scope because they also recognise the challenges of getting legislation through a hung Parliament.

10. We warmly welcome, at least in principle, proposed changes that seek to extend the range of options and flexibilities available for those working across local health and care economies who are trying to integrate their services (the creation of new NHS trusts for integrated care), manage their resources effectively (flexibilities to agree prices locally) and take decisions jointly (the establishment of joint committees). We are supportive of the intent behind NHS England and NHS Improvement's proposals to promote collaboration, which will see the law change to give greater weight to collaboration as an organising principle that underpins how the NHS is planned and managed. We agree that collaboration, rather than competition, is a better way to manage the rising demands on health and social care, improve joined up care for patients and deliver better value for taxpayers. The current mechanisms for competition in the NHS continue to add costs and complexities in too many areas without corresponding benefit in return for patients and taxpayers. We do, however, recognise the role that choice can play in raising standards and encouraging innovation, and do not seek to return to what one witness described as an 'airless room' which excludes all other providers.⁹

11. Therefore, we broadly support NHS England and NHS Improvement's proposals to:

- repeal section 75 of the Health and Social Care Act 2012, and revoke the regulations made under it;
- remove the Competition and Market's Authority's role in mergers of foundation trusts;
- ease the burden procurement rules have placed on the NHS, ensuring commissioners have discretion over when to conduct a procurement process, with the inclusion of a 'best value' test; and
- allow greater flexibility locally over payment systems.

12. The NHS is a mixed quasi market, comprised of statutory and non-statutory services. The legislative proposals do not change this. To do so may require potentially more fundamental and far reaching reforms that would constitute another top-down reorganisation of the NHS. Our view is that reform to this degree is not warranted at this time. Also, as we said in our last report, a diverse health and care economy can be an enabler of integration, rather than a barrier to it. However, as market forces will continue to operate in the NHS, although to a lesser extent, it is important that the proposals put forward should not allow deregulation of the market without including alternative regulatory mechanisms. Careful oversight of these changes to competition rules is important to ensure the interests of patients and taxpayers are protected. In particular, while welcome in principle, much more detail is needed on how a ‘best value’ test will operate, including the definition of value that will underpin such a test. We support a test that embraces a broad definition of public and social value, but it is important that the design and implementation of this test does not create a more onerous set of arrangements than procurement rules currently pose. We also heard concerns about the operation of ‘best value tests’ in local government which, though different, go by the same name.

13. NHS England and NHS Improvement’s proposals continue, in many respects, the direction of travel that has been established since the NHS Five Year Forward View was published in October 2014. That is towards a more integrated, collaborative, place-based approach to the planning and delivery of health and care, which breaks down traditional divides that have characterised the NHS since its inception in 1948. The Forward View clearly acknowledged that, while the NHS is a national health service, England is too diverse and complex for a one-size fits all approach. Local autonomy and leadership have been a core feature of the changes that have been taking place across the health and care system over recent years.¹⁰

14. That is why some witnesses were concerned by the degree of centralisation that could occur as a result of these changes. This worry was expressed by several witnesses across the health and social care community, including leaders of local providers, commissioners and local systems. On balance, we believe that merging NHS England and NHS Improvement will benefit those working on the NHS front line, who have experienced conflicting messages from the two bodies. However, this will further centralise power. In addition, increasing NHS Improvement’s powers over foundation trusts’ decisions to merge or spend capital, for example, greatly extends the ability of the NHS at a national level to make decisions about the way local services are configured and how local resources are managed, especially if the CMA’s role is removed and NHS England and NHS Improvement merge. While we agree that the NHS at a national level may need to intervene as a last resort to address disputes within a local system, our view is that the proposals give too much power to the NHS at a national level. We think that these two proposals need to be reviewed to reflect those concerns.

15. We are also unclear how giving the Secretary of State the ability to transfer, or require the delegation of, functions from one arms-length body to another will be used to support integrated care. We would like to see more detail on how this will improve joined up care and value for patients.

16. NHS England and NHS Improvement’s proposals in many cases continue the direction of travel towards a more integrated collaborative and place-based system.

10 NHS England, [NHS Five Year Forward View](#), October 2014

While there is broad support for that direction of travel, it remains too NHS-centric rather than looking at the wider system with which it seeks to integrate. One potential unintended consequence of some of the proposed changes (changes to procurement, the ‘best value’ test and joint committees) is that the NHS could become an unresponsive, self-serving monopoly - a criticism that was made of previous NHS structures such as district health authorities.¹¹ The Department of Health and Social Care, NHS England and NHS Improvement should be clearer about the roles local government, the voluntary and community sector and independent providers should play in the future of the NHS.

17. In particular, organisations from across the health and care community have expressed concern that local government was not part of the main narrative articulated in the NHS Long-term Plan.¹² These proposals do little to address that criticism. Local authorities and Health and Wellbeing Boards are crucial if integrated care systems are going to result in approaches that focus on population health and are truly place-based. More work is needed across several of the proposed changes to work through the implications for local authorities (e.g. procurement rules and local government’s involvement in joint committees) to ensure that barriers to local authority involvement in the planning and delivery of services are removed.

18. In the interests of not imposing another top-down reorganisation on the NHS, we are of the view that now is not the right time to establish all integrated care systems as separate legal entities. To do so would risk undermining some of the progress local systems have made to build relationships and ways of working together. However, we are concerned that the governance and accountability of integrated care systems, and the regional tiers of NHS England and NHS Improvement that sit above them, are complex, slow and weak. We recommend that all STPs and ICSs should meet the highest standards of openness and transparency in the conduct of their affairs by holding meetings in public and publishing board papers and minutes. Transparency is not as good as formal accountability, but to avoid another top-down reorganisation of the NHS, we believe it is the most pragmatic way forward.

11 [Q107](#) Rt. Hon. Patricia Hewitt

12 See paragraphs 107 and 108

2 Competition

Background

19. Over the last 30 years, successive governments have pursued the goal of greater integration alongside policies that sought to increase the role of choice and competition within the NHS. The NHS Health Service and Community Act 1990 created the so-called NHS internal market, with a split between the provision and commissioning of healthcare through the creation of self-governing trusts and GP fund-holders. The NHS internal market continued to develop throughout the 1990s, but accelerated at the turn of the century with a series of reforms, under a Labour government, including the introduction of payment by results, the establishment of foundation trusts, and an extended role for the private sector.¹³

20. The Health and Social Care Act 2012 took this much further, seeking to make competition the key organising principle of the NHS. It introduced, for the first time, a formal purchaser/provider split at the top of the NHS. NHS England was created as an independent commissioning board, overseeing the newly created Clinical Commissioning Groups, and itself purchasing/commissioning specialist services. Unlike many of their predecessors, for example primary care trusts, CCGs had no provider role. Patients became able to choose a range of services from “any qualified provider” – whether from the public or independent sector. The NHS provider side was overseen by the Trust Development Authority where NHS organisations had yet to become foundation trusts, while Monitor’s role as the foundation trust regulator was hugely extended to become that of a market regulator, charged with preventing anti-competitive behaviour by NHS purchasers. One impact of these changes was that more NHS services, which play a key part in integrating care, notably community services, were put out to tender. In a recent report on integrated care, the National Audit Office concluded that:

shifts in policy emphasis and reorganisations which promote competition within the NHS, such as the move from primary care trusts to clinical commissioning groups in 2013 and the Health and Social Care Act 2012, have complicated the path to integration.¹⁴

21. In our report on integrated care, we emphasised that collaboration and quality, rather than competition between providers, should be the organising principles that underpin the planning and delivery of NHS care. A mixed economy of health and care provision is not necessarily at odds with the integration agenda. Patients, we heard during our previous inquiry, often draw on a wide variety of services and sources of support, from the NHS, but also charities, social enterprises and private providers, to meet their needs. What matters is whether a patient’s care is coordinated and centred on their needs. Patients must be at the heart of any reforms. To call the health service integrated if it fails to achieve this goal misses the point. Our view was that integration is enhanced by a diverse local health and care economy, made up of mostly public, but also non-statutory,

13 House of Commons Health and Social Care Committee, [Integrated care: organisations, partnerships and systems](#), HC650, 11 June 2018

14 National Audit Office, [Health and social care integration](#), HC1011 February 2017

providers that work together in the interests of patients. The key question is how to enable those providing care to achieve this aim and do so without unnecessarily burdensome bureaucratic hurdles.

Economic regulation

22. NHS England and NHS Improvement propose a series of changes to the role of competition within the NHS, including the role of the Competitions and Markets Authority (CMA) and NHS Improvement (technically, powers given to Monitor under the 2012 Act). The consultation document proposes to:

- Revoke regulations made under section 75 of the Health and Social Care Act 2012 and repeal powers in primary legislation under which the regulations are made.
- Remove NHS Improvement’s competition powers and duties.
- Remove the CMA’s role in reviewing mergers between NHS foundation trusts.
- Remove the requirement for NHS Improvement to refer contested licence conditions and national tariff provisions to the CMA.¹⁵

23. NHS England and NHS Improvement’s proposals to promote collaboration and lessen the role of competition in the English NHS have been warmly welcomed by the health and care community during the course of our inquiry, especially the proposal to repeal section 75 of the Health and Social Care Act 2012 and revoke the regulations made under it. These proposals do not remove the role of competition entirely from the NHS. To do so would require more fundamental and far reaching reforms. However, competition, as a lever for improving quality, has in practice been diluted over recent years.¹⁶ Some of the mechanisms in place to regulate competition have only been used on a handful of occasions. There is still a role for competition in the NHS, but encouraging organisations to collaborate, rather than compete, is widely regarded as a better way to manage the rising demands on health and care system.¹⁷ According to the Health Foundation:

These developments represent an important shift in direction for NHS policy. The 2012 Act aimed to strengthen the role of competition in the NHS, consolidating a market-based approach to reform that has been in place since the establishment of the internal market in 1991. By 2019, however, competition rarely gets mentioned in NHS policy. Instead, the Five Year Forward View, STPs, and ICSs are based on the idea that collaboration—not competition—is essential to improve care and manage resources, including between commissioners and providers.¹⁸

24. One criticism of NHS England and NHS Improvement’s proposals we heard was that these changes could deregulate, rather than de-marketise, the NHS, without introducing an alternative regulatory mechanism.¹⁹ Market mechanisms can be, and have been, used

15 NHS England and NHS Improvement, [Implementing the NHS Long Term Plan: Proposals for possible changes to legislation](#), February 2019

16 Health Foundation ([NLN0039](#)), King’s Fund ([NLN0052](#))

17 Health Foundation ([NLN0039](#))

18 Health Foundation ([NLN0039](#))

19 Dr Albert Sanchez-Graells ([NLN0001](#)), Mr Andrew Taylor ([NLN0002](#))

to a greater or lesser extent as levers for improvement.²⁰ The NHS operates a mixed (quasi) market, with a mixed economy of provision.²¹ NHS England and NHS Improvement's proposals do not change this, but remove some of the ways this NHS market is regulated. We heard that where markets are used they need to be regulated, especially in healthcare, to ensure service providers behave in ways that support the interests of their customers, in this case patients, and taxpayers.²² By removing an NHS-specific set of rules, NHS England and NHS Improvement's proposals might subject the NHS to more general rules.²³ Andrew Taylor, former Director of the Cooperation and Competition Panel for NHS-funded services, argued that:

Under the Long-Term Plan, markets in NHS services will remain, albeit their role is likely to be reduced. However, NHS England's proposals will remove many of the oversight systems that are aimed at making market-based mechanisms in the NHS achieve positive outcomes. In many ways, NHS England's proposals will deregulate NHS markets, rather than de-marketise the NHS.²⁴

25. When viewed alongside some of the other changes proposed by NHS England and NHS Improvement, removing regulations that govern the NHS market, including the CMA's role, could result in a significant centralisation of power in these national bodies.²⁵ For example, coupled with proposed changes for NHS Improvement to direct mergers and acquisitions involving foundation trusts, the removal of the CMA's NHS-specific role could result in a scenario when the NHS at a national level can direct mergers and judge its own decisions.²⁶ A national top-down style of command and control, which has been used extensively in the NHS's history,²⁷ can exert a strong alternative system of governance.²⁸ However, we heard stakeholders, especially NHS providers, commissioners and system leaders, express concern about the degree of centralisation proposed, especially when the direction of travel, certainly since the development of STPs and arguably since the Forward View, has been towards empowering collaborative, placed-based systems locally. A greater role for local Health and Wellbeing Boards and local Healthwatch could, as the Nuffield Trust suggest, offer an alternative source of scrutiny that could fill the void left by competition.²⁹

Competition and Markets Authority

26. In principle, we have heard widespread support for the changes to the CMA's role in the NHS that NHS England and NHS Improvement suggest, albeit with some notable caveats. The CMA's functions, we heard, are just one example where competition rules have added complexities and costs into the system, with little benefit in return. For example, we heard that the experience of providers who have been seeking mergers or acquisitions,

20 Mr Andrew Taylor ([NLN0002](#))

21 Dr Albert Sanchez-Graells ([NLN0001](#))

22 Mr Andrew Taylor ([NLN0002](#))

23 Mr Andrew Taylor ([NLN0002](#)),

24 Mr Andrew Taylor ([NLN0002](#))

25 NHS Confederation ([NLN0047](#)), Dr Albert Sanchez-Graells ([NLN0001](#))

26 NHS Confederation ([NLN0047](#))

27 The Health Foundation, [Glaziers and windowbreakers: the role of the Secretary of State for Health, in their own words](#), May 2015

28 Allen, P. BMC Health Services Research 2013, 13(Suppl 1):S1 <http://www.biomedcentral.com/1472-6963/13/S1/S1>

29 Nuffield Trust ([NLN0009](#))

in order to address workforce challenges for example, is that the CMA adds unnecessary duplication.³⁰ The NHS Confederation told us that many of its members said “that they did not think the CMA had been the right body to fulfil the functions expected of it, and they regarded it as an unnecessary layer of bureaucracy.”³¹ This sentiment is shared by others across the health and care community, as well as the CMA itself, in some cases.³²

Mergers

27. As mentioned above, NHS Improvement and NHS England propose to remove the CMA’s role in reviewing mergers between NHS foundation trusts. This is one example where removing NHS-specific rules could result in the NHS becoming subject to general competition rules. We heard that, while the CMA’s NHS-specific role would go, foundation trust mergers would remain subject to the general powers in the Enterprise Act, unless the legislation specifically states that foundation trusts are no longer to be considered “enterprises” for the purpose of the Act.³³

Objections to national tariff and licence conditions

28. NHS Improvement sets conditions for the provider licence and the national tariff, although it does so jointly with NHS England in the latter case. Relevant bodies, under provisions in the 2012 Act, can object to the method proposed for setting the national tariff and conditions of the provider licence. Where a sufficient proportion do so, NHS Improvement must either consult on a revised set of proposals or make a referral to the CMA.³⁴ No such referral has ever happened and the CMA does not believe it is well placed, as a general competition regulator, to intervene anyway.³⁵ However, in the event that NHS England and NHS Improvement merge, NHS providers are keen to ensure that there remains a mechanism for independent adjudication of disputes covering these points.³⁶

29. **We warmly welcome, in principle, NHS England and NHS Improvement’s proposals to promote collaboration, especially the proposal to repeal section 75 of the Health and Social Care Act 2012 and revoke the regulations made under it. We believe collaboration, rather than competition, as an organising principle, is a better way for the NHS and the wider health and care system to respond to today’s challenges.**

30. **We heard concerns that NHS England and NHS Improvement’s proposals risk deregulating, rather than de-marketising, the NHS without creating an alternative regulatory mechanism. In its response to this report, we request that the Government set out its assessment of the likelihood that the proposed legislation would have the effect of deregulating competition in the NHS and how it intends to ensure patients and taxpayers are protected from any adverse unintended consequences.**

31. **We support NHS England and NHS Improvement’s proposal to remove the need for NHS Improvement to refer objections on the national tariff and provider licence**

30 NHS Providers ([NLN0011](#)), NHS Confederation ([NLN0047](#))

31 NHS Confederation ([NLN0047](#))

32 Competition and Markets Authority ([NLN0017](#)),

33 Competition and Markets Authority ([NLN0017](#)), Mr Andrew Taylor ([NLN0002](#))

34 NHS England and NHS Improvement, [Implementing the NHS Long Term Plan: Proposals for possible changes to legislation](#), March 2019

35 Competition and Markets Authority ([NLN0017](#))

36 NHS Providers ([NLN0011](#))

conditions to the CMA. No referral has ever been made and the CMA, as a general competition regulator, is not best placed to intervene in these matters. Nonetheless we share the concerns of providers about the removal of this safeguard altogether and recommend that the Department, NHS England and NHS Improvement build in a mechanism for independent adjudication of challenges to these decisions.

32. We welcome the intention behind removing the Competition and Markets Authority's NHS-specific role in overseeing mergers involving foundation trusts. The CMA's role, we heard, has led to unnecessary cost and duplication for foundation trusts involved in mergers and acquisitions. However, to remove foundation trusts entirely from the CMA's remit would, we heard, require the law to change so that foundation trusts are no longer considered as 'enterprises' under the Enterprise Act. We recommend that the Department, together with NHS England and NHS Improvement, seek legal advice on the changes that will be required to remove foundation trusts from the CMA's jurisdiction and the implications of doing so.

National tariff

Background

33. NHS England and NHS Improvement's consultation document describes the national tariff as:

a set of currencies (e.g. defined episodes of care), prices and rules governing the payments that NHS commissioners make to providers for NHS-funded healthcare (except for primary care services). It is intended to promote high-quality care and improve the efficiency with which services are provided. The tariff is set on an annual or multi-year basis.

34. Healthcare systems around the world use a variety of different payment systems. The national tariff is one example. The Health Foundation argue that an effective system ought to combine multiple payment methods coupled with a focus on improvement.³⁷ The King's Fund suggest that, rather than designing a complex set of incentives, an alternative is to move away from contracts towards a focus on building effective partnerships supported by simple arrangements that allow resources to be moved around when needed.³⁸

35. While it can be useful, paying for activity, as the national tariff does, creates perverse incentives that are a barrier to integration. The tariff-based system has been traditionally used to incentivise hospital activity. However, there is broad consensus that preventing the need for patients to go to hospital is generally better for patients and taxpayers alike. Dr Amanda Doyle, the Chief Officer of Healthier Lancashire and South Cumbria, explained that the tariff systems works well for a traditional model of care whereby people are referred to hospital, treated, cured and then discharged, but less well for the management of patients with multiple long-term conditions where incentives should be in place to promote prevention and to reduce the need for admission. Dr Doyle explained that:

37 Health Foundation ([NLN0039](#))

38 The King's Fund, [Payments and contracting for integrated care: the false promise of the self-improving health system](#), March 2019

if somebody has a number of long-term conditions whereby they may have a small part of their care in a hospital setting, but a much bigger part of their care in a community or primary care setting, if a hospital provider is incentivised to increase the number of episodes of care in the hospital because of the financial regime under which they are working, you are not necessarily using your resource in the most effective way or treating your patient in the place where it is going to be most effective for their best outcomes.³⁹

Local flexibility

36. The proposed changes to the tariff seek to give local systems more flexibility in their payment systems and more responsibility to local systems for managing resources. NHS England and NHS Improvement propose that:

- it should be possible for national prices to be set as a formula rather than a fixed value, so that the price payable can reflect local factors;
- local commissioners and providers should be able to agree appropriate payments for services patients receive from their main hospital under tariff rules, but that powers should enable national prices to apply in specific circumstances such as out of area treatments;
- once ICSs are fully developed, the power to apply to NHS Improvement to make local modifications to tariff prices should be removed.⁴⁰

37. Allowing greater flexibility to adjust tariff prices to reflect local needs and circumstances is broadly welcomed, although more information is needed on the formula that would be introduced. More flexible use of the tariff, combined with the use of other payment systems, would enable local areas to use tariff payments, not as a rule, but at the margins, where this makes sense locally. A national tariff, we heard, creates problems for rural, high-cost areas, for example.

38. One of the potential unintended consequences of allowing more flexibility at a local level is that it could introduce an incentive for providers to compete on price, rather than quality. This is another example of how these proposals can be seen as deregulating market forces within the NHS. We heard that it will be important to ensure that the local flexibilities do not result in a ‘race to the bottom’ where providers compete on price, at the expense of quality.⁴¹ While the risk of price competition has been raised by many as a possibility, we have heard different opinions about the extent to which the changes NHS England and NHS Improvement propose would lead to conditions in which price competition is likely.⁴²

39. Another potential problem is that these changes add complexity to the system, especially for certain providers. One of the benefits of the national tariff is that it has simplified arrangements. There is a concern that these changes could lead to protracted

39 [Q101](#) Dr Doyle

40 NHS England and NHS Improvement, [Implementing the NHS Long Term Plan: Proposals for possible changes to legislation](#), March 2019

41 NHS Confederation ([NLN0047](#)), IHPN ([NLN0012](#))

42 Competition and Markets Authority ([NLN0017](#)), Mr Andrew Taylor ([NLN0002](#))

negotiations between providers and commissioners. Greater local flexibility could also end up adding complexity to the way large providers, which cover multiple areas, are paid. For example, Jon Rouse, Chief Officer of the Greater Manchester Health and Social Care Partnership, explained:

If you are a major teaching hospital, you do not want 15 or 16 different versions of a pricing mechanism for the same provision of care, the same specialty, and you are left trying to make sense of 16 different ways of paying for the same thing in different geographies.⁴³

40. Currently, providers in specific circumstances, such as when a local service is economically unviable, can apply to NHS Improvement to request that national prices can be modified locally. NHS England and NHS Improvement propose to remove this power, as they argue it is “out of keeping” with the move towards encouraging organisations in a local system to take collective responsibility for managing their own resources.⁴⁴ However, in terms of oversight, we heard that there is a strong case for retaining the ability for providers to apply to NHS Improvement to make local modifications to tariff prices, as even when ICSs are fully developed they may not be the most appropriate place to pool risk in cases where local services are deemed economically unviable.⁴⁵ In addition, according to NHS Providers:

Providers recognise that when ICSs are fully formed the need for NHSI to make local price modifications should become less necessary. But, in many systems, local price modification is a matter for often complex and difficult negotiation between providers and commissioners. We think there is a good argument for retention of NHSI’s power of intervention on local price modification, especially whilst the journey to integrated local systems is in train and potentially beyond that.⁴⁶

Nevertheless, the proposals to allow more flexibility in respect of pricing were generally supported by those from whom we heard evidence, as they reflect the current reality of how local commissioners and providers allocate resources.

41. We support NHS England and NHS Improvement’s intention to provide greater local flexibility over the use of the national tariff system. Providing more flexibility will help local providers and commissioners to remove perverse incentives, especially in managing patients with multiple long-term conditions. One of the benefits of a national tariff system is that it has helped to ensure that providers compete on the quality, rather than the price, of the care they deliver. In its response, we request that the Department, together with NHS England and NHS Improvement, outline how they plan to avoid and/or mitigate the concern that these changes could result in price competition.

43 [Q108](#) Jon Rouse

44 NHS England and NHS Improvement, [Implementing the NHS Long Term Plan: Proposals for possible changes to legislation](#), March 2019

45 King’s Fund ([NLN0052](#)),

46 NHS Providers ([NLN0011](#))

Procurement

42. NHS England and NHS Improvement propose to repeal section 75 of the Health and Social Care Act 2012 and remove the NHS from the Public Contract Regulations 2015, and replace these regulations with a new ‘best value’ test.⁴⁷ Simon Stevens, Chief Executive of NHS England, told us that these proposals are intended to ensure that commissioners can exercise discretion about when to carry out a formal procurement process, albeit with certain safeguards applied in order to protect taxpayers’ interests.⁴⁸

43. During the course of our inquiry, we heard varied views on the extent to which NHS commissioners put contracts out to tender. Ian Dalton said that “any contract over £615,278 is, by and large, tendered; that is clearly a lot of contracts.”⁴⁹ Other written and oral evidence we received suggested that the total number of contracts commissioners put out to tender is small.⁵⁰ Research into CCG contracting carried out on behalf of the Independent Healthcare Providers Network suggests that over the last three years the total number of NHS contracts put out to tender has ranged from 6% to 12%, although these contracts only equate to a small percentage (between 2 and 3%) of the total value of NHS contracts.⁵¹

44. Nevertheless, there was acceptance that competitive tendering is more widespread in respect of community health services and mental health services. Ian Dalton, for example, argued that running a competitive tendering process has become an expected part of doing business in community health services.⁵²

45. For those involved, procurement rules add considerable costs and complexities into the system that, it is argued, are of little benefit to patients. We heard how procurements create a transactional relationship between providers and commissioners,⁵³ characterised by seemingly endless contracting rounds. In addition to the transaction costs and administrative burdens procurements create, we heard how the experience can be disruptive for staff.⁵⁴

46. We also heard that problems stem not only from the procurement rules themselves, but also from people’s interpretation of these rules and their difficulty in understanding what is permissible within the rules. On the commissioner side, we heard that CCGs often undertake what is called ‘defensive procurement’, whereby contracts are put out to tender in order for the commissioners to avoid legal challenges.⁵⁵ Uncertainty over what is legally permissible within the procurement rules has also been a barrier to providers seeking to work together to integrate their services.⁵⁶

47 NHS England and NHS Improvement, [Implementing the NHS Long Term Plan: Proposals for possible changes to legislation](#), March 2019

48 [Q52](#) Simon Stevens

49 [Q53](#) Ian Dalton

50 IHPN ([NLN0012](#)), [Q189](#) David Hare, [Q249](#) Sharon Lamb

51 IHPN ([NLN0012](#))

52 [Q53](#) Ian Dalton

53 King’s Fund ([NLN0052](#))

54 [Q53](#) Ian Dalton

55 [Q7](#) Professor Checkland

56 NHS Providers ([NLN0011](#)), NHS Confederation ([NLN0047](#)), King’s Fund ([NLN0052](#))

47. On the point of integration, Simon Stevens explained that “just trying to run procurements for the community health services sliver, is to completely miss the point.” He went on to explain that:

we need far more integration between both community health and primary care and community health and specialist care. Doing carve-outs of the sort you describe [for example by commissioning community health services separately] is precisely what we will be getting away from as we implement the long-term plan.⁵⁷

48. NHS Improvement and NHS England propose removing the NHS from the Public Contract Regulations 2015 (PCR 2015). These regulations implement EU procurement rules. We heard from witnesses that there is legal debate as to whether the NHS in England might need to move to a more administered system than is currently proposed (as is the case in Scotland and Wales) to escape them.⁵⁸ We also heard, including from lawyers and academics specialising in this area, that there are greater flexibilities that could be taken advantage of within PCR 2015 than is currently the case.⁵⁹ We are not in a position to make a judgement on either possibility. But given the complexities, NHS England and the Department will require specialist legal advice about how to implement this proposed change, depending on the status of Brexit at the time that the proposed amendments to NHS legislation are brought forward.

Best value test

49. There is broad support for the principle of a ‘best value’ test, although more detail is needed on how the test will operate. We heard consistently that it is difficult to assess the merit of this proposal adequately until further detail is available about how the test will work. However, the evidence we have taken provides some high-level points about how this idea can be developed.

50. We heard that the definition of value that underpins the ‘best value’ test must be broad, with a focus not only on the efficiency and quality of care (including health outcomes of patients), but also the NHS’s ability to deliver wider public and social value. As Rob Harwood from the British Medical Association Consultants Committee stressed, it must not be a “least cost test”.⁶⁰ Similar tests used in local government have three main elements, encompassing economic, social and environmental value.⁶¹ Aligning the NHS to similar concepts of value used by other public services would be an important safeguard in ensuring that a ‘best value’ test operates in the interests of patients and the public.⁶² There are opportunities to use a ‘best value’ test to develop the NHS’s role an anchor institution, as Jon Rouse described:

I get quite excited when I begin to think about importing social value properly into an NHS assessment of how best to commission or buy services. If you think about the amount that the NHS spends in a local economy and the good that could do if there was built into it both testing of how to

57 [Q61](#) Simon Stevens

58 Dr Albert Sanchez-Graells ([NLN0001](#)), [Q265](#) Christian Dingwall, [Q265](#) David Lock

59 Dr Albert Sanchez-Graells ([NLN0001](#)), [Q265](#) Christian Dingwall

60 [Q222](#) Rob Harwood

61 [Q118](#) Jon Rouse

62 Social Enterprise UK ([NLN0059](#))

provide, and obligations on who provides—around apprenticeships, around how goods are procured and around sustainability—the impact could be absolutely massive. We spend £6 billion a year in Greater Manchester on our health system. Imagine that being harnessed to that cause.⁶³

51. A best value test must reduce, rather than add to, the burdens on providers and commissioners. The concept of a ‘best value’ test is designed to enable commissioners to exercise discretion over whether to put a service out to tender. However, a ‘best value’ test could end up being more onerous than the current process, depending on how the test is designed and implemented. There is also the prospect of such a test leading to an increase, rather than a reduction, in legal challenges, as Andrew Taylor suggested:

At the moment, effectively people are making those decisions [whether to put a service out to tender] behind closed doors and maybe someone does or does not have a go, but what you are doing is introducing transparency and rules around that kind of decision making, and that will make it much more contentious and liable to challenge.⁶⁴

52. It is important that a ‘best value’ test does not allow the NHS to become a protectionist monopoly provider. There are differing views over whether a ‘best value’ test should start from the position of the NHS as a preferred provider of services. This may help to keep the test less onerous.⁶⁵ However, the majority of the evidence given to this inquiry has stressed the importance of ensuring that the test does not become a means for the NHS to exclude non-statutory providers. Commissioners must retain the ability to test new models of provision.

53. While the concept of a ‘best value’ test had broad support, the language of ‘best value’ may not be the most appropriate terminology to use. Within local government, ‘best value’ has negative connotations because it is perceived as being synonymous with cost-cutting. Sara Gorton from UNISON explained:

Our members will associate ‘best value’ with a very specific set of changes that were made in local authorities to what had been the compulsory competitive tendering regime. That was softened by best value, which was introduced with the intention of allowing progressive tendering and contractual relations that did not just take lowest cost as a measure. However, the subsequent financial challenges across the sector mean that, for many staff working in that environment, best value is still associated with broad cost-cutting. Our strong recommendation would be that you should dissociate from that.⁶⁶

54. We support the intent behind NHS England and NHS Improvement’s proposal to ensure that commissioners can exercise discretion over when to conduct a procurement process. The practice of procurement in parts of the NHS, particularly community and mental health services, has added complexities and costs to the system, with little added value for patients in return, and made it harder for services to integrate.

63 [Q118](#) Jon Rouse

64 [Q201](#) Andrew Taylor

65 [Q238](#) Dr Gerada

66 [Q237](#) Sara Gorton

55. Given the way the NHS in England operates, the proposal to take it out of the Public Contract Regulations 2015 may well face legal difficulties. NHS England, NHS Improvement and the Department need to explore that in detail and be clear about the law, including EU law. In the meantime, however, we recommend that they should explore whether there are more flexibilities within PCR 2015 than are currently being used.

56. We recommend that the Department, NHS England and NHS Improvement work with the NHS Assembly to co-produce a ‘best value’ test. This test should be underpinned by a broad definition of value, with the quality of care and health outcomes at its heart, but also aligned with conceptions of public and social value used by other public services. As the term ‘best value’ is perceived in local government to be synonymous with cost-cutting, we strongly advise that NHS England and NHS Improvement reconsider the using the phrase ‘best value’.

3 Patient choice

Background

57. There is a range of choices that patients should expect to be offered when using NHS services. These are central to the way the NHS operates and, as well as being mandated in legislation, the policy drive to strengthen, enhance and improve choice has been highlighted in many recent NHS publications. The NHS Constitution states that patients have the right to choose any NHS provider (that is clinically appropriate) for their first consultant-led outpatient appointment. Patients also have the right to be offered an alternative provider if they have not received a consultant-led outpatient appointment within 18 weeks of a referral from their GP. NHS England and NHS Improvement are proposing ways to strengthen patient choice and control, including the roll out of personal health budgets (PHBs).⁶⁷

58. The proposals for changes to legislation published for consultation by NHS England in February 2019 included “stronger protection for patient choice.”⁶⁸ This strengthening of protection for patient choice was proposed to be implemented by explicitly amending the power to set standing rules in primary legislation to require inclusion of patient choice rights. Simon Stevens, Chief Executive of NHS England, explained that what was being proposed was not only to protect but to enhance patient choice, which was already safeguarded as a statutory right for patients.⁶⁹ This view was echoed by many stakeholders. Dr Amanda Doyle, Chief Officer of Healthier Lancashire and South Cumbria, said that there was nothing in the proposals that:

suggests losing the obligation to offer choice at the point of referral, or the obligation to re-offer choice after a lengthy delay in wait for treatment.⁷⁰

59. Although the proposals have been generally welcomed in relation to their impact on patient care, concerns were raised about unintended consequences, particularly over the lack of clarity about several aspects of the proposals. One such example was presented to us by Professor Pritchard, Director for Health and Social Care at Social Enterprise UK. She was concerned that there was a risk that the proposals could lead to a reduction in choice, if commissioners made decisions using a version of a best value test that led to non-NHS providers being excluded from provision of services to NHS patients.⁷¹ Another was explained by Sharon Lamb of legal firm McDermott Will and Emery, an expert in NHS regulatory and contracting matters:

The issue of revoking the 2013 regs⁷² is that effectively you remove the right for providers to be listed if they achieve or meet commissioner requirements or standards. By removing the 2013 regs, you effectively remove the right

67 NHS England and NHS Improvement, [Implementing the NHS Long Term Plan: Proposals for possible changes to legislation](#), March 2019

68 NHS England and NHS Improvement, [Implementing the NHS Long Term Plan: Proposals for possible changes to legislation](#), March 2019

69 [Q42](#) and [Q49](#) Simon Stevens

70 [Q109](#) Dr Doyle

71 [Q285](#) Professor Pritchard

72 The National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013. See paras x to y above (procurement).

to be listed on an AQP list on NHS Choices, so you have cut off half of the choice entitlement. It is not enough to say that patients have a constitutional right to choice if you do not also allow the market to provide.⁷³

The reality of patient choice

60. The ability of patients to choose who provides their care is an important right. In practice, however, the ability of patients to actually exercise this choice is constrained by numerous factors, most notably where they live. Those living in a metropolitan area may have a range of choices which are not available to people living in other parts of the country, as Rob Harwood, Chair of the BMA Consultants Committee, explained.⁷⁴ Professor Checkland, Professor of Health Policy and Primary Care, University of Manchester, and a practising GP, pointed out that “in my area, choice tends to be geographical. The patients who live nearer Sheffield go to Sheffield, and the patients who live near Chesterfield go to Chesterfield, and that is all they care about—transport links.”⁷⁵ She also explained that “as a GP, my lifelong experience is that, although some people want choice around the edges, most of my patients just want their local hospital to be good.”⁷⁶ This point was supported by Dr Gerada, former Chair of the Royal College of General Practitioners, who stressed that while choice is important, the overriding priority should be ensuring “safe, local services that deliver good-quality care to their patients, based on need, not want.”⁷⁷

61. Retaining patients’ right to choose between providers is undisputed. What is disputed is the extent to which the ability of patients to choose helps to create safe, good quality services. When the money follows the patient, as is the case under the payment by results system, patient choice can act as an incentive for providers to improve.⁷⁸ However, after 30 years of the NHS internal market, evidence is lacking to support the use of competition as the overriding organising principle of how health and care is organised.⁷⁹ Patient choice can be useful “in areas like planned operations, specialist outpatients, and talking therapies,” according to the Nuffield Trust.⁸⁰ In the context of the integrated care which these legislative proposals are intended to facilitate, Simon Stevens explained that local areas are mainly focusing on joining up the ongoing care of patients with long-term conditions, rather than one-off procedures which are more likely to be subject to patient choice.⁸¹

62. The development of integrated care providers and systems is likely to result in a shift in the way health and care services are incentivised, which could undermine patient choice. For example, integrated care providers, and integrated care systems, will be incentivised to provide services within their organisations or partnerships, although a patient may

73 [Q270](#) Sharon Lamb

74 [Q229](#) Dr Harwood

75 [Q12](#) Professor Checkland

76 [Q12](#) Professor Checkland

77 [Q228](#) Dr Gerada

78 Nuffield Trust ([NLN0009](#))

79 Health Foundation ([NLN0039](#)), King’s Fund ([NLN0052](#))

80 Nuffield Trust ([NLN0009](#))

81 [Q49](#) Simon Stevens

benefit from being referred elsewhere, as the Nuffield Trust argued.⁸² One way to guard against this would ensure that there remains a distinct role for commissioners and/or ICSs that is separate from provider interests.⁸³

63. We support the intention of NHS England and NHS Improvement’s proposals to strengthen patient choice. The evidence we have taken in the course of this inquiry suggests that practical considerations such as geography have a greater influence on the exercise of patient choice than legislation, and that what most patients want is good quality care close to their home. Using patient choice as a lever to improve quality may help for some services, particularly planned or elective care, but as an organising principle, we believe that encouraging collaboration between providers is a much better way to provide good-quality care for patients, especially those with multiple long-term conditions. Nonetheless, witnesses to our inquiry accepted the desirability of maintaining and enhancing patient choice in the NHS. Those developing the proposals should ensure that they do not have unintended consequences that negatively impact on the ability of patients to exercise their right to choose between providers.

Appeals concerning patient choice

64. It is proposed, as part of the changes designed to enable collaboration, to remove NHS Improvement’s competition powers and duties. The aim of this is to make supporting improvement in the quality of care, and the use of NHS resources, the organisation’s primary focus. A consequence of this proposal would be to remove NHS Improvement’s role as a complaints body, including directly resolving individual issues when a patient believes that their right to choice has been denied.

65. We heard that the number of complaints relating to patient choice has been low.⁸⁴ Nevertheless, the ability for patients to be able to access a suitable appeal mechanism when they believe their right to choice has been denied is important. Unless otherwise provided for, future enforcement of these rules would instead be through the courts. This would inevitably be slower and more expensive than the current enforcement regime.⁸⁵

66. We do not suggest a particular body to conduct this work but note that the low number of complaints is likely to make the establishment of a new agency to deal with this specific issue undesirable. This view was supported by David Hare, Chief Executive of the Independent Healthcare Providers Network, who also emphasised that the enforcement body should be independent from the provider of care.⁸⁶ The Care Quality Commission or the Independent Reconfiguration Panel could potentially take on this appeals function.

67. Having a right to choice relies on that right being enforceable. We recommend that an appeal mechanism is preserved, within an existing independent body, for patients who believe they have been denied choice.

82 Nuffield Trust ([NLN0009](#))

83 Nuffield Trust ([NLN0009](#))

84 [Q212](#) Andrew Taylor

85 Mr Andrew Taylor ([NLN0002](#))

86 [Q213](#) David Hare

4 Integrating care provision

68. It is possible to organise services in various ways to support integrated care for patients. In essence, there are ways of removing or reducing the barriers separate organisational boundaries pose for integration. Integrating contracts and organisations is not the same as integrating care for patients. During our last inquiry, and again in this one, we heard frequently that a patient's experience of integration depends much more on the behaviours, culture and infrastructure in place locally which support integration, rather than on the specific organisational forms integration take.⁸⁷

69. The organisational form integrated care takes ranges from partnerships between existing services at one end of the spectrum through to the formal consolidation of services into a single organisation at the other end. Integrated care partnerships, which have emerged out of the New Care Models programme, are the most common form in the NHS at present. There are two broad types: alliance and prime provider models. An alliance model is where a partnership of different health and care providers holds an alliance contract for a range of services, which enables these services to collaborate. A prime/lead provider model is similar, but in this model one provider, such as a foundation trust or local authority, takes the lead. While these options provide useful ways to reduce or remove organisational boundaries the NHS Confederation told us that:

Some of our members who supported the concept of integrated care trusts nevertheless believed many provider organisations were not ready, or in some cases willing, to join up at this point. Alongside the legislative proposals, we believe more work is needed to address the underlying reasons why providers do not feel they can come together using existing flexibilities or by merging. Part of this is almost certainly down to the lack of system-wide incentives to pool risk and share rewards.⁸⁸

70. In Dudley, the NHS is attempting to formalise an existing partnership into a single organisation, which would then hold an Integrated Care Provider contract (ICP contract). Dudley's plans represent the first attempt to apply these arrangements in the NHS.

71. The original term proposed, accountable care organisation (ACO), creates confusion with the Affordable Care Act 2010 in the US. The term integrated care provider (ICP) is now used in place of the term ACO to reflect the point that the use of this model in the English NHS is likely to be very different from the model of the same name used in other countries.⁸⁹ There are many benefits to creating an ICP in the English NHS. ICPs offer, for example, the opportunity to bring a disparate array of services, particularly out of hospital services, into a single organisation, with one workforce and aligned incentives that enable resources to be shifted away from hospitals and towards improving population health.⁹⁰

87 Health and Social Care Committee, [Integrated care: organisations, partnerships and systems](#), Seventh report of Session 2017–19, HC 650, NHS Confederation (NLN0047)

88 NHS Confederation (NLN0047)

89 Health and Social Care Committee, [Integrated care: organisations, partnerships and systems](#), Seventh report of Session 2017–19, HC 650

90 Health and Social Care Committee, [Integrated care: organisations, partnerships and systems](#), Seventh report of Session 2017–19, HC 650

72. The widespread use of the term ACO sparked concerns, and misconceptions, about how these models might be used in the English NHS. Most notably, campaign groups have asserted that ACOs could extend the privatisation of the NHS, if private companies are allowed hold long-term contracts for a wide variety of NHS services. In fact, we heard that the opposite is more likely, as the private sector has little appetite to bid for such contracts and commissioners are more likely to use an ICP model to formalise partnerships between NHS services, rather than to contract services out to the private sector. Nevertheless, we strongly recommended that ICPs should be established in primary legislation as NHS bodies to put this beyond doubt.⁹¹

73. Integrating contracts and services is not the same as integrating care for patients. Nevertheless, there already exist different contractual and service options, permissible within existing legislation, that help to remove or reduce the barriers which organisational boundaries pose to integration. More work is needed to understand why some services are currently unable or unwilling to make use of these arrangements. We recommend that the National Implementation Plan/ framework should include proposals to increase the uptake of existing contractual options and/or further extend the ways organisations can work collaboratively.

Integrated care provider contract

74. The NHS has developed an Integrated Care Provider contract, as a way to establish integrated care providers within the English NHS. Many parts of the NHS are achieving similar aims with alternative models, such as alliance contracts and prime provider contracts, but an ICP contract provides a mechanism which caters for the interest some local health systems have expressed in “bringing some services together under the responsibility of a single provider organisation, supported by a single contract and a combined budget.”⁹²

75. NHS England and NHS Improvement’s proposals state that there is a clear expectation that holders of an ICP contract will be public statutory providers, but that ICP contract holders will not have to provide all the relevant services themselves.⁹³ Holders of an ICP contract may subcontract services from GPs, voluntary and community services and the independent sector, where the contract holder deems this necessary.⁹⁴ This approach provides a way to ensure the risk entailed in an ICP contract rests with a public statutory provider, but without removing the ability of the NHS to draw on the mixed economy of health and care provision available across the country. Where such a provider exists, it is likely that they will carry out similar functions currently undertaken by CCGs. The governance and accountability of these providers therefore requires careful attention. The creation of a large integrated care provider, when viewed alongside changes to allow joint committees of providers and commissioners to be created in ICSs, may result in new conflicts of interest that will need to be managed, as the Nuffield Trust describe.⁹⁵

91 Health and Social Care Committee, [Integrated care: organisations, partnerships and systems](#), Seventh report of Session 2017–19, HC 650

92 NHS England and NHS Improvement, [Implementing the NHS Long Term Plan: Proposals for possible changes to legislation](#), February 2019

93 NHS England and NHS Improvement, [Implementing the NHS Long Term Plan: Proposals for possible changes to legislation](#), February 2019

94 NHS England and NHS Improvement, [Implementing the NHS Long Term Plan: Proposals for possible changes to legislation](#), February 2019

95 Nuffield Trust ([NLN0009](#))

76. Despite assurances by NHS England and NHS Improvement that ICP contract holders are expected to be public statutory bodies, the prospect of non-statutory providers holding an ICP contract has not been ruled out.⁹⁶ Our previous inquiry on integrated care concluded that in practice the use of ICPs in the English NHS is likely to reduce the need for competitive tendering, thereby lessening, rather than extending, the private sector's involvement in the NHS.⁹⁷ Nonetheless, the prospect of a private provider holding an ICP contract remains unpalatable to many.⁹⁸ UNISON's written evidence argues that:

[...] for the avoidance of doubt the proposals could be strengthened by making clear that ICP contracts have to be held by public bodies. This would go even further in assuaging the concerns of staff and campaigners that there remains some residual prospect of ICP contracts ending up in private hands.⁹⁹

77. It has been widely accepted that the holder of an ICP contract should be an NHS body, as suggested by us and by NHS England. We note that, in its response to consultation on the latest draft of the ICP contract, NHS England has suggested that the contract should go into use before the legislative change has been made.¹⁰⁰ Making an ICP contract available at this stage means there will be no legal bar on non-NHS providers holding one. There is no urgency to use such a contract. We heard during our last inquiry that its use will be piloted in Dudley and potentially Manchester.¹⁰¹ We are not aware of any other local areas that are seeking to adopt this model at this stage. However, now is not the time to make the contract available for widespread use. As we mentioned in our previous report, the introduction of an ICP model requires careful monitoring and evaluation to assess its merits within the English NHS.¹⁰²

78. We welcome assurances from NHS England and NHS Improvement that holders of an Integrated Care Provider contract are expected to be public statutory providers, but with the ability to subcontract with a range of other partners. This proposal would achieve a sensible balance by enabling ICP contract holders to draw on the diverse mix of health and care provision that exists across the country, while ensuring the responsibility entailed in these long-term contracts rests with public statutory bodies.

79. We strongly recommend that legislation should rule out the option of non-statutory providers holding an ICP contract. Doing so would allay fears that ICP contracts provide a vehicle for extending the scope of privatisation in the English NHS.

80. Given the political climate, we recognise that legislation may not be brought before the House of Commons for some time. Until legislation is passed, we strongly urge that ICP contracts should be piloted only in a small number of local areas and subject to careful evaluation and that they should not be held by non-statutory providers.

96 UNISON ([NLN0028](#))

97 Health and Social Care Committee, [Integrated care: organisations, partnerships and systems](#), Seventh report of Session 2017–19, HC 650

98 British Medical Association ([NLN0037](#)), UNISON ([NLN0028](#)), Prof Sue Richards, Keep Our NHS Public ([NLN0053](#))

99 UNISON ([NLN0028](#))

100 'Contracting arrangements for integrated care providers – response to consultation' NHS England March 2019

101 Health and Social Care Committee, [Integrated care: organisations, partnerships and systems](#), Seventh report of Session 2017–19, HC 650

102 Health and Social Care Committee, [Integrated care: organisations, partnerships and systems](#), Seventh report of Session 2017–19, HC 650

New NHS Integrated Care Trusts

81. There is broad support for giving the Secretary of State the power to create new NHS trusts for the purpose of delivering integrated care in an area. By creating a new NHS trust the Secretary of State will help commissioners who may struggle to identify an existing organisation that can hold an ICP contract.

82. The key advantage of creating a new NHS trust, according to Jon Rouse, Chief Officer of Greater Manchester Health and Social Care Partnership, is that it provides a mechanism for giving participating services an equal stake in the organisation. This may not be possible in other models, in which one organisation, such as a foundation trust, is the lead provider. As Mr Rouse told us:

At the present time, we have some very successful prime provider models in both Salford and Tameside, and those organisations work hard to make them feel like they are a collation of equal providers, but the reality is that they are run by the foundation trust—by the acute trust—which has turned itself into a much more integrated care provider. This option may bring something that is genuinely, in a more equal way, primary care, community health and so on, and feels that equivalence within the ownership of the trust.¹⁰³

83. We heard that the creation of a new NHS trust must have buy-in from the local health and care economy and represent an efficient use of local resources. A new NHS trust is only one of the options. Creating a new NHS trust of this kind, according to NHS Providers, is likely to be complex and time consuming, especially since any such trust would be responsible for providing a wide range of services.¹⁰⁴ The creation of a new NHS trust could also have a destabilising effect on a local health and care economy. While it may be advantageous in some circumstances, we heard that the decision to create a new NHS trust should be preceded by a period of engagement with the local health and care community, including staff and patients, in order to ensure there is buy-in locally. There was widespread support for using the proposed ‘best value’ test to inform the creation of a new NHS trust to ensure this decision represents the most efficient use of public resources, and that similar objectives cannot be achieved through less disruptive means.

84. More detail is required on the governance and accountability of these new NHS trusts. The Local Government Association has argued that new NHS trusts should have statutory duties to improve population health and deliver integration, so that the duties on these bodies “mirror the contractual duties and responsibilities within the ICP contract” and are aligned with the duties on clinical commissioning groups, health and wellbeing boards and local authorities.¹⁰⁵

85. There may be a need to ensure appropriate safeguards are applied to avoid the creation of new NHS trust being used inappropriately. The value of this power is that it provides a mechanism for the Secretary of State to extend the options available to local commissioners, where such a provider is desired locally. However, NHS Providers warned that this power could be used by national bodies as a lever to force, or threaten,

103 [Q130](#) Jon Rouse

104 NHS Providers ([NLN0011](#))

105 Local Government Association ([NLN0051](#))

services to collaborate.¹⁰⁶ Doing so would be counter-intuitive given that the success of any organisational form integration takes depends more on the relationships, culture and behaviours at a local level.

86. We support the proposal to give the Secretary of State the power to create a new NHS trust to deliver integrated care in an area. This change to the legislation will extend the ways in which local commissioners can integrate health and social care. Our view is that this power must not be used by the Secretary of State to impose a form of integration on local health and care services or as threat to incentivise organisations to collaborate. We recommend that the Secretary of State must not be allowed to exercise this power without a request from the local clinical commissioning group(s).

87. We recommend that a request to the Secretary of State must follow a robust assessment and public consultation to ensure the creation of a new NHS trust is in the best interests of patients and the local population, and represents an efficient use of public money.

VAT regulations

88. Different VAT regulations covering NHS bodies, local authorities and non-NHS providers are an example of barriers to integration within the system. For example, some NHS to NHS contracting is exempt from VAT (NHS contracting out services regime), which enables NHS bodies to reclaim VAT from HMRC.¹⁰⁷ However, this provision ceases to exist when the chain of NHS to NHS contracting is broken.¹⁰⁸ This is what happened in the failure of Uniting Care Partnership in Cambridge, where two foundation trusts established a limited liability partnership to hold a prime provider contract with the CCG. As the contract was held by a private company, the chain of NHS to NHS contracting was broken and the two trusts were liable in respect of VAT on services they provided to the CCG, where previously the services they provided would have been exempt.¹⁰⁹

89. These VAT restrictions affect not only integration between the NHS and non-statutory providers, but also integration with local authorities.¹¹⁰ Christian Dingwall explained how:

if the NHS were to delegate, under the section 75 partnership regulations that we have discussed, its NHS commissioning to a local authority, we will run into the same problem about upsetting the contracting-out services regime. That is a problem in respect of local authorities getting involved in the contracting.¹¹¹

90. Local authorities also have separate VAT exemptions (known as partial exemption rules) where full recovery of VAT is permitted provided councils remain within their partial exemption limit. They may present a problem, as Mr Dingwall, explained: “if a local authority delegates its commissioning to the NHS, it may run into problems with

106 NHS Providers ([NLN0011](#))

107 National Audit Office, [Investigation into the collapse of the UnitingCare Partnership contract in Cambridgeshire and Peterborough](#), HC 512 Session 2016–17 14 July 2016; [Qq271–276](#)

108 [Q271](#) Christian Dingwall

109 National Audit Office, [Investigation into the collapse of the UnitingCare Partnership contract in Cambridgeshire and Peterborough](#), HC 512 Session 2016–17 14 July 2016

110 [Q272](#) Christian Dingwall

111 [Q272](#) Christian Dingwall

VAT recovery under the partial exemption rules.”¹¹² These exemptions save millions of pounds for the NHS and local authorities so it is important that reforms to integrate care do not upset either regime.¹¹³

91. As Simon Stevens explained in his oral evidence to the Public Accounts Committee’s inquiry into the Uniting Care Partnership in Cambridge:

[...] the VAT rules are quite complicated as between type of bidder; so one of the complaints is that in some ways there is not a level playing field, in that if you are an NHS bidder you have a different VAT look-through than if you are not, and different types of cost within a contract are subject to different VAT rates; so it is not just 20% across the board, in or out.¹¹⁴

92. We recommend the Government’s forthcoming review of VAT exemptions on central government should also make recommendations for how VAT exemptions covering the NHS and local government can be protected and/or extended so as to ensure neither body is worse off as a result of integration.

112 [Q272](#) Christian Dingwall

113 [Q271](#) Christian Dingwall

114 Public Accounts Committee, [Oral evidence: UnitingCare Partnership Contract](#), 14 September 2016, HC 633, Q186
Simon Stevens

5 Integrated care systems

93. Sustainability and transformation partnerships (STPs) are partnerships between different organisations within a local health and care system: clinical commissioning groups, NHS trusts and foundation trusts, local authorities, GPs, the voluntary and community services and other partners. The partnerships were originally established to develop plans for the future of health and social care at a local level, but have evolved to become ‘core units of NHS planning’ and performance management.¹¹⁵ Integrated care systems are advanced forms of STPs which have been granted more autonomy from the NHS at national level over how they manage their collective resources.

94. STPs and ICSs vary in the size of the populations they serve and the number of bodies involved. The geography of some STPs and ICSs is logical, reflecting one natural community, with coterminous boundaries between the individual organisations involved. This is not true everywhere. As the Nuffield Trust point out:

Some [STP and ICS boundaries] make obvious sense and reflect transport and patient flows. Others are not so logical and seem to have been determined by the need to address issues of acute trust configuration. STPs such as Cheshire and Merseyside; Hertfordshire and West Essex; and Bath, North East Somerset, Swindon and Wiltshire do not map to one natural community but rather combine bits of several, with patients being referred out to different specialist hospitals. They cut across systems, rather than uniting them.¹¹⁶

Governance and accountability

95. Neither STPs nor ICS are statutory bodies. Their authority is derived from the decision-making powers of the individual organisations that comprise them. STPs and ICSs have used memorandums of understanding, committees in common and joint committees [between CCGs and local authorities] as ways for individual organisations to work together and take decisions jointly.¹¹⁷ In our previous report on integrated care we concluded that these workarounds, while pragmatic, are cumbersome and risky. They distance decision-makers from the decisions they are making and complicate lines of accountability.¹¹⁸ These arrangements often lead to duplication and slow decision-making.¹¹⁹ Perhaps most importantly, these arrangements are voluntary; partners can ultimately walk away if they choose to.¹²⁰

96. NHS England and NHS Improvement’s proposals extend the ways local systems (STPs and ICSs) can take decisions together, but the governance and accountability of STPs and ICSs is likely to remain complex, slow, risky and weak even with these new arrangements.¹²¹ Rather than establish ICSs as statutory bodies, NHS England and NHS Improvement are proposing to extend the ways in which individual organisations within

115 Health Foundation ([NLN0039](#))

116 Nuffield Trust ([NLN0009](#))

117 King’s Fund ([NLN0052](#))

118 Health and Social Care Committee, [Integrated care: organisations, partnerships and systems](#), Seventh report of Session 2017–19, HC 650

119 King’s Fund ([NLN0052](#))

120 King’s Fund ([NLN0052](#))

121 King’s Fund ([NLN0052](#)) [Q19](#) Nigel Edwards

an ICS can take decisions jointly. These proposals reflect flexibilities local systems have asked for, but they are voluntary.¹²² How an ICS decides to make decisions will be left to its own discretion: they will not be compelled to adopt any of the arrangements NHS England and NHS Improvement propose.¹²³ Partners will still be able to walk away.

97. These arrangements may result in new conflicts of interest to manage. For example, the Nuffield Trust points out, when viewed alongside changes to integrated care provision, “we could see the same people operating as providers within the ICP, accountable to the ICS on which they also sit and also potentially accountable to the local CCG of which they may be a member if they are a GP.”¹²⁴

98. It is not clear how ICSs will be held to account for poor performance and how they will involve and engage the public. There are strong mechanisms for public and patient involvement at a local level, in the shape of local Healthwatch and Health and Wellbeing Boards, but this is not mirrored with ICSs at a regional level.¹²⁵ We heard from witnesses that the role Health and Wellbeing Boards play in some systems has helped to build in a form of local democratic accountability.¹²⁶

99. An important question is whether the governance and accountability of STPs and ICSs is robust enough for the big, and potentially difficult and divisive, decisions local areas may face in the not too distant future.

100. There is a broad consensus that governance and accountability of STPs and ICSs is far from ideal and that the law will need to change eventually to establish ICSs as separate legal entities. However, the key question for now is whether the potential upheaval such legislation may cause outweighs the problems posed by the complexities and ambiguities surrounding the governance and accountability of integrated care systems.¹²⁷ NHS England and NHS Improvement, and others, argue that the risks of legislating too soon outweigh the problems posed by the complexity and ambiguity surrounding the governance and accountability of ICSs, for two reasons.¹²⁸

101. Firstly, creating ICSs as a separate legal entity, we heard, would constitute a major restructuring of the NHS, as it would require other fundamental changes to the role and accountabilities of clinical commissioning groups and foundation trusts, for example.¹²⁹ There remains very little appetite for a major top-down restructuring of this kind. As Professor Chris Ham argued:

the difficulty in creating ICSs now as statutory bodies is that you would have to rip up not just the 2012 Act but all the prior legislation, and start again. That would amount effectively to another major top-town reorganisation of structures, which I do not think anybody wants. It is perhaps better to live with some of the complexities and ambiguities we have, with the transparency you are talking about.¹³⁰

122 [Qq74–78](#), [Q25](#) Richard Murray

123 [King’s Fund \(NLN0052\)](#), [Q25](#) Richard Murray

124 [Nuffield Trust \(NLN0009\)](#)

125 [Q304](#) Sir Robert Francis

126 [Qq144–146](#) and [Q20](#) Nigel Edwards

127 [King’s Fund \(NLN0052\)](#), [Q22](#) Richard Murray

128 [Qq74–78](#), [King’s Fund \(NLN0052\)](#), [Q22](#) Richard Murray

129 [Qq74–78](#), [Q22](#) Richard Murray, [Q135](#) Professor Ham

130 [Q135](#) Professor Ham

102. Secondly, STPs and ICSs are still developing, and it would be difficult, and potentially detrimental, to define now the legal form ICSs should take. Getting the relationships right at a local level is fundamental to the success of ICSs. The absence of a national blueprint for STPs and ICSs has, we heard, helped, rather than hindered, progress,¹³¹ as local leaders have had space to build and define relationships themselves without being directed from above.¹³² Legislating too soon risks undermining the relationships local leaders are forging together. Legislation could be used, as Patricia Hewitt suggested, to establish an optional legal form that ICSs could adopt in a couple of years.¹³³ However, local system leaders warned us of the danger of over-specifying, at this point in time, forms of governance and accountability, which are then imposed on local systems across the country.¹³⁴ Richard Murray, Chief Executive of The King's Fund told us that:

These [ICSs] are emerging around England; they look different and behave in a different way, and they are trying to establish their own internal governance. Yes, I think we will, ultimately, end up in a place where they need to be statutory, but beware of the risks of plumping for one model now. The problem with a lot of health legislation in the past is that it was invented in Whitehall and then cookie-cuttered all over the country in a model that has not worked. There is a tension.¹³⁵

103. In the absence of establishing more formal accountabilities for ICSs, the next best thing, we heard, may be to ensure ICSs are open and transparent in their conduct. Jon Rouse invited us to Manchester to see how a similar model is applied there. He stated that:

If it would be helpful for any members of the Committee, or indeed your support team, to come to one of our health and care board meetings, which are in public, are webcast and all the papers are published, you would be very welcome to see that in action. It is politically chaired, and the Mayor of Greater Manchester always comes. We get quite a few leaders of councils as well as NHS organisations at those meetings.¹³⁶

104. The issue of the accountability of integrated care systems (ICSs) and sustainability and transformation partnerships is very important, and not easily solved in the absence of their establishment as statutory bodies. While we agree that it is not advisable at this time to establish all integrated care systems as separate legal entities, in the absence of formal accountability for their collective decision-making, we expect ICSs to meet the highest standards of openness and transparency in the conduct of their affairs by holding meetings in public and publishing board papers and minutes. Transparency, however, is not an adequate substitute for accountability if it is not clear who should be held to account. It is vital to avoid creating a situation where everyone in the system is accountable, but no-one can be held responsible for important decisions. We recommend that the National Implementation Plan due this autumn should set further directions for the standards of governance and transparency local systems should demonstrate.

131 [Q141](#) Professor Ham

132 Health and Social Care Committee, [Integrated care: organisations, partnerships and systems](#), Seventh report of Session 2017–19, HC 650

133 [Q106](#) Rt Hon. Patricia Hewitt

134 King's Fund ([NLN0052](#)), [Q22](#) Richard Murray

135 [Q22](#) Richard Murray

136 [Q138](#) Jon Rouse

Joint committees

105. Rather than establishing ICSs as separate legal entities, the consultation document puts forward proposals to extend the ways in which individual organisations within an ICS can take decisions jointly. NHS England and NHS Improvement propose that CCGs and NHS trusts and foundation trusts should be able to create joint committees to exercise collective decision-making.¹³⁷ This proposal mirrors existing flexibilities that enable CCGs and local authorities to form joint committees and pool budgets. With this in mind, NHS England and NHS Improvement are exploring the prospect of local authorities participating in joint committees with CCGs and NHS providers, where this is agreed by all parties at a local level.¹³⁸ NHS England and NHS Improvement also suggest that it would be sensible to allow NHS providers to form their own joint committees, which may include representation from non-statutory providers, including primary care networks, GP practices or the voluntary sector.¹³⁹

106. While welcome as a useful extension to the ways ICSs can currently take decisions together, we heard that this proposal is very NHS-focused. Organisations from across the health and care community, including local authorities, the voluntary and community sector, social enterprises and private providers, require more clarity about how ICS decision-making can involve a broad range of local stakeholders. Witnesses warned that one notable risk is that joint committees between CCGs and NHS providers could result in ICSs becoming unresponsive monopolies, in which the NHS operates in its own interest rather than that of patients. As Niall Dickson from the NHS Confederation argued, it is important to:

[...] make sure that [these legislative proposals] achieve what we all want to achieve, which is greater local autonomy, not less local autonomy, and a system that fosters integration and, from our perspective, does not lead to monopolies at local level that then become self-satisfied or mediocre.¹⁴⁰

107. There was broad consensus that the arrangements for joint committees should build in “appropriate scrutiny and challenge—for example, through lay and non-executive involvement and local democratic oversight”¹⁴¹ and duties to involve patients and the public, including their representatives.¹⁴² More clarity is needed about the role of Health and Wellbeing Boards (HWBs) in ICSs. The Local Government Association argued that HWBs could be used in place of joint committees, rather than as separate entities alongside them.¹⁴³

108. We heard that it is important that local authorities should be able to participate as equal partners in ICSs.¹⁴⁴ Having local authorities around the table is important to enable

137 NHS England and NHS Improvement, [Implementing the NHS Long Term Plan: Proposals for possible changes to legislation](#), February 2019

138 NHS England and NHS Improvement, [Implementing the NHS Long Term Plan: Proposals for possible changes to legislation](#), February 2019

139 NHS England and NHS Improvement, [Implementing the NHS Long Term Plan: Proposals for possible changes to legislation](#), February 2019

140 [Q150](#) Niall Dickson

141 King’s Fund ([NLN0052](#))

142 [Q304](#) Sir Robert Francis, [Q304](#) Beth Capper

143 Local Government Association ([NLN0051](#))

144 Local Government Association ([NLN0051](#)), [Q152](#) Sarah Pickup [Q158](#) Sarah Pickup

integrated care systems to focus on population health and to be genuinely place-based.¹⁴⁵ As local democratic institutions, local authorities can play an important role in providing political input into, and support for, difficult decisions that ICSs need to take.¹⁴⁶

109. We agree that the law should change to enable clinical commissioning groups and NHS providers (NHS trusts and foundation trusts) to establish joint committees.

110. We are concerned that the proposals are currently too NHS-centric. Integrated care systems must not repeat mistakes of the past and become unresponsive monopolies or “airless rooms” where non-statutory alternatives are shut out.

111. Local authorities must be part of the decision-making process in order for integrated care systems to be truly place-based and focused on population health. We recommend that additional proposals should be developed that enable local authorities to participate as equal partners in joint committees with clinical commissioning groups and NHS providers.

Triple aim

112. NHS England and NHS Improvement propose that a new shared duty should be introduced that requires those organisations that plan services in a local area (CCGs) and NHS providers of care 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 the wider NHS. The consultation also states that “the legal duties that currently apply to various bodies might need to be amended or extended to ensure they are consistent across all organisations and support this triple aim.”¹⁴⁷

113. The introduction of a new shared duty is widely supported, although some witnesses thought it to be too narrow and NHS-centric. For example, the duty appears to be specifically targeted to CCGs and NHS providers rather than local authorities and other local partners. We heard that the reference to health, rather than wellbeing, or both health and wellbeing, reflected a focus on the NHS rather than the wider health and social care sector. Expanding the duty to include wellbeing may be a useful amendment. Health, as we were told by Dr Charlotte Augst, CEO of National Voices, is only one part of the wellbeing agenda.¹⁴⁸ Expanding the duty to include wellbeing may help to bring in other system partners, as Dr Augst described:

We want to make a partnership and shared responsibility approach in places happen. Local governments do not subscribe to the triple aim; they are held accountable for the wellbeing of their communities through the Care Act. Many VCS organisations would not work towards the triple aim. They do not provide health services in that way; they are engaged in improving people’s wellbeing. We think it would be useful to start a conversation about whether wellbeing would not be a more useful outcome, if we want to lock an outcome into legislation.¹⁴⁹

145 Local Government Association ([NLN0051](#)), [Q145](#) Professor Ham, [Q178](#) Sarah Pickup

146 Local Government Association ([NLN0051](#))

147 NHS England and NHS Improvement, [Implementing the NHS Long Term Plan: Proposals for possible changes to legislation](#), February 2019

148 [Q297](#) Dr Augst

149 [Q297](#) Dr Augst

114. Despite broad support amongst other witnesses, representatives of NHS providers are sceptical about the value this new duty will add and how it will work in practice. More information is needed on whether, and if so how, compliance with the duty would be monitored, incentivised and enforced. According to the NHS Confederation “it is difficult to see what adding an additional duty to promote the triple aim would mean in practice for trust boards.”¹⁵⁰ It seems likely that existing duties on different bodies will need to be revised to avoid any contradiction or duplication. More information is required on how these existing duties would be amended.

115. **We welcome the proposal to introduce a shared duty that requires organisations that plan services in a local area (CCGs) and NHS providers to “promote the triple aim of better health for everyone, better care for all patients and the efficient use of NHS resources, both for their local system and for the wider NHS.” Nevertheless, the proposal as currently framed is too NHS-centric. The term ‘better health’ was viewed by witnesses, particularly representatives of the voluntary and community sector, as focused on the NHS. Wellbeing, in contrast, was seen as a more inclusive term which reflects the contribution local government and the voluntary and community sector make to people’s lives. Wellbeing is also an intrinsic part of the World Health Organisation’s definition of health. We recommend that the “triple aim” should be rephrased to include a specific reference to wellbeing.**

Barriers to system working

116. NHS England and NHS Improvement have proposed that:

- NHS Improvement should have targeted powers to direct mergers or acquisitions involving foundation trusts, in specific circumstances, where there are clear patient benefits.
- NHS Improvement should have powers to set annual capital spending limits for NHS foundation trusts.

117. These proposals expand the ability of NHS Improvement to intervene where an NHS foundation trust is using its freedoms to the detriment of the system. According to NHS Providers, the NHS Confederation and the Shelford Group, both changes undermine the foundation trust model by reducing the freedoms foundation trusts have and cutting across the duties and accountabilities the boards of NHS foundation trusts have towards their local populations.¹⁵¹

118. It is widely accepted that the NHS, at a national level, may need to intervene in circumstances where one local partner is acting against the interests of the local system and that NHS England and/or NHS Improvement, or a merger of these two bodies, will need to have powers reserved should such circumstances arise. However, the powers proposed are widely regarded as blunt, inappropriate and another attempt from centre to assert greater control over local decision-making.¹⁵² Instead, we heard that the objective should be to encourage and empower local systems to resolve problems themselves.

150 NHS Confederation ([NLN0047](#))

151 NHS Providers ([NLN0011](#)), NHS Confederation ([NLN0047](#)), Shelford Group ([NLN0024](#))

152 NHS Providers ([NLN0011](#)), NHS Confederation ([NLN0047](#)), King’s Fund ([NLN0052](#))

Mergers and acquisitions

119. NHS England and NHS Improvement propose to give NHS Improvement targeted powers to direct mergers or acquisitions involving NHS foundation trusts. Under this change, NHS Improvement would be able to direct NHS foundation trusts to consider or prepare for a merger or acquisition as well as to merge (with another NHS trust or foundation trust) or be acquired (by another foundation trust).

120. NHS Improvement, exercising the powers of the Secretary of State, can currently direct mergers or acquisitions involving NHS trusts. However, NHS Improvement can only take similar action in respect of NHS foundation trusts when they are subject to trust special administration. That is in exceptional circumstances where there is a serious risk of failure. In proposing to extend NHS Improvement's powers to cover foundation trusts, the document acknowledges that this power should only be exercised in specific circumstances, where there are clear patient benefits, and that appropriate safeguards would be required. During our inquiry we heard from witnesses that a lot more detail is required on several points, including:

- The specific circumstances in which NHS Improvement will be able to exercise this new power and what circumstances would trigger its use.¹⁵³ The King's Fund suggested that if introduced, the powers should be very specific and only used in exceptional cases.¹⁵⁴
- The safeguards that will be introduced.¹⁵⁵ For example, the removal of the CMA's role would leave local organisations with little ability to challenge directions from NHS Improvement to merge.¹⁵⁶ As noted in Chapter 1 providers are keen that some form of independent adjudication remains, even if it does not remain as a role of the Competition and Markets Authority.¹⁵⁷
- How patient benefits will be defined and assessed.¹⁵⁸
- The protections for staff employed in the organisations involved.¹⁵⁹

121. These proposals are seen by some stakeholders, especially those representing foundation trusts, as undermining the freedoms foundation trusts have and the accountability of their boards. As NHS Providers notes in its written evidence:

It is fundamental to trust autonomy and accountability that the trust board should determine its trust's configuration—for example, through a merger or acquisition—is fundamental to its autonomy and, therefore, its accountability. It is inappropriate for such changes to be directed from above. It is mistaken and against all governance good practice to require a unitary board to undertake any activity with which it disagrees. It is

153 Academy of Medical Royal Colleges ([NLN0022](#)) NHS Providers ([NLN0011](#)), NHS Confederation ([NLN0047](#)), King's Fund ([NLN0052](#))

154 King's Fund ([NLN0052](#))

155 British Medical Association ([NLN0037](#)), NHS Confederation ([NLN0047](#)), Shelford Group ([NLN0024](#))

156 NHS Confederation ([NLN0047](#))

157 NHS Providers ([NLN0011](#)), NHS Confederation ([NLN0047](#))

158 British Medical Association ([NLN0037](#)), Royal College of Nursing ([NLN0014](#)), NHS Confederation ([NLN0047](#))

159 British Medical Association ([NLN0037](#)), Royal College of Nursing ([NLN0014](#))

impossible to hold a board to account if it has been forced to undertake a merger or acquisition that it believes is inappropriate and is not in the best interest of the trust or the community it serves.¹⁶⁰

122. While recognising that national bodies may need to intervene, many stakeholders across the health and care community are therefore sceptical about whether this is the most appropriate mechanism. The evidence on the success of mergers, according to The King’s Fund, is mixed at best and mostly disappointing.¹⁶¹ The NHS Confederation that argue that mergers are more successful where they are “locally led in the interest of local patients” and where there are strong relationships between the organisations involved.¹⁶² Imposing a merger could undermine integration, rather than support it. Therefore, many stakeholders are against a scenario where the default position is to direct a merger.¹⁶³

123. NHS Providers argue that the power to direct mergers is a blunt instrument, as it forces a board to do something against their will.¹⁶⁴ Instead, NHS Improvement could seek to use some of the regulatory powers it already has, including, in extreme cases, the ability to remove board directors.¹⁶⁵ NHS Providers argues that the use of these existing regulatory powers would be preferable as they set a higher bar for action by NHS Improvement.¹⁶⁶ In the most extreme example, NHSI would need to find alternative board directors willing to undertake a merger.¹⁶⁷

124. Perhaps the strongest reservation about this proposal is that it reflects concerns about an unhelpful shift of power towards NHS England and NHS Improvement, in that it takes responsibility and autonomy away from local systems.¹⁶⁸ There is widespread view that local leaders are better placed to make decisions of this nature than their counterparts nationally.¹⁶⁹ As Professor Chris Ham, STP Chair and former CEO of The King’s Fund, argued:

It feels to me that surely this is what we should be looking to the systems to take responsibility for, not forcing mergers, but to say that in our system there is an issue about the sustainability of local specialised services and we, as a system, because we are being given more responsibility for money, performance and planning, see it as part of our role to grasp these difficult nettles and come forward with proposals on how the sustainability of specialist services can best be addressed. The knowledge will rest, I think, in most places, within those systems, more so than at a national body or indeed in the regional office.¹⁷⁰

160 NHS Providers ([NLN0011](#))

161 King’s Fund ([NLN0052](#))

162 NHS Confederation ([NLN0047](#))

163 King’s Fund ([NLN0052](#)), NHS Confederation ([NLN0047](#)), Health Foundation ([NLN0039](#))

164 NHS Providers ([NLN0011](#))

165 NHS Providers ([NLN0011](#))

166 NHS Providers ([NLN0011](#)), [Q167](#) Chris Hopson

167 NHS Providers ([NLN0011](#)), [Q167](#) Chris Hopson

168 [Q124](#) Professor Ham, [Q108](#) Jon Rouse, [Qq168–169](#) Niall Dickson, [Q165](#) Chris Hopson

169 [Q124](#) Professor Ham, [Qq168–169](#) Niall Dickson, [Q165](#) Chris Hopson

170 [Q124](#) Professor Ham

Capital spending

125. The consultation proposes that NHS Improvement should be given powers to set annual capital spending limits for NHS foundation trusts. This change would effectively mirror the powers NHS Improvement have over NHS trusts.¹⁷¹ The rationale for NHS England and NHS Improvement’s proposals is that, with freedom over how and when to spend capital funding, it is possible that foundation trusts may use their freedoms in manner which results in a detriment to other partners within an STP or ICS, and therefore to the system as a whole.¹⁷²

126. We heard from witnesses, particularly NHS Providers, the NHS Confederation and the Shelford Group, that limiting capital spending undermines the accountability of trust boards.¹⁷³ NHS Providers argue that “the anomaly in the current system is, in fact, the power over NHS trust capital investment, not the absence of that power over NHS foundation trusts. To discharge their accountability effectively, provider boards must have the appropriate powers.”¹⁷⁴ The proposal for NHS Improvement to set capital spending limits for NHS foundation trusts is, in its view, another example of a potentially unhelpful shift in power towards the centre. In its written evidence, NHS Providers argue that:

Capital maintenance and investment is a key part of service delivery, and we question the circumstances under which NHS Improvement would be better placed to make a decision here than the trust board, especially given that the consequences for under-investment will sit with the trust and its board. It does not appear that the national bodies would be taking on additional accountability to balance this power to intervene and direct.¹⁷⁵

127. Providers argue that risks posed by exceeding capital limits stem more from systemic problems at a national level about the process for determining the amount of capital requirement and for prioritising and allocating capital resources than from local decision-making.¹⁷⁶ According to the Shelford Group, a coalition of leading NHS foundation trusts, far greater concerns over capital spending exist, namely:

the approach to defining the total quantum of capital required across the NHS, the balance across the different types of capital investment required (eg. estate, equipment & IT), the propensity for capital to revenue adjustments at a national level to remain within the RDEL and the mechanism for prioritising investment across regions and organisations. It is in relation to these factors that the capital model is fundamentally flawed and failing patients.¹⁷⁷

171 NHS England and NHS Improvement, [Implementing the NHS Long Term Plan: Proposals for possible changes to legislation](#), February 2019

172 NHS England and NHS Improvement, [Implementing the NHS Long Term Plan: Proposals for possible changes to legislation](#), February 2019

173 NHS Providers ([NLN0011](#)), NHS Confederation ([NLN0047](#)), Shelford Group ([NLN0024](#))

174 NHS Providers ([NLN0011](#))

175 NHS Providers ([NLN0011](#))

176 NHS Providers ([NLN0011](#)), Shelford Group ([NLN0024](#))

177 Shelford Group ([NLN0024](#))

Mergers and acquisitions and capital spending: conclusions

128. Local systems should be empowered to decide the most appropriate way to manage NHS resources. This includes being encouraged to resolve disputes between local partners about the best way to manage resources, including capital resources, within the system. There may be circumstances in which national intervention is necessary to ensure one local partner is not, unreasonably, frustrating system-wide efforts. NHS England and NHS Improvement should have powers in reserve for such circumstances, but such powers should be used only as a last resort.

129. We do not, therefore, support these proposals in their current form. If similar proposals are brought before us for pre-legislative scrutiny in the form of the expected draft bill, we will expect to see the proposed legislation specify the limited circumstances in which these powers can be exercised. The design of these powers should focus on a) removing barriers to integrated care and b) empowering and encouraging local systems to resolve disputes over the configuration of services and the management of resources, including capital resources, themselves.

6 National bodies

Background

130. The 2012 Act made significant changes to the landscape of organisations that sit at the top of the NHS and the wider health and social care system. In many ways, the duties and functions of these national bodies were designed to facilitate the operation of choice and competition within the NHS. During our previous inquiry, we heard of a number of ways in which the national architecture of the NHS poses a barrier to more integrated, collaborative and place-based working.¹⁷⁸

131. NHS England and NHS Improvement (comprising Monitor and the NHS Trust Development Authority) are the two organisations with the greatest responsibility for setting the direction of, and overseeing, the NHS. These two bodies mirror the purchaser/provider split at a national level. During our last inquiry we heard how, as the NHS locally has developed through the formation of sustainability and transformation partnerships and integrated care systems, having two bodies at the top of the NHS has resulted in conflicting messages for those on the front line. In response to this concern the two organisations are already working closely together to align what they do, provide more joined-up support for local health systems, and establish integrated teams to carry out most of their functions.¹⁷⁹ Evidence to this inquiry supports the view that the current close working relationships has been successful in a number of cases, an example being the joint work between the two organisations on the Five Year Forward View for Mental Health.¹⁸⁰

132. However, this joint working is limited by current legislative constraints. The two organisations are unable to formally carry out functions jointly, there are constraints on sharing board members and there are separate accountability arrangements to the Secretary of State.

Future of NHS England and NHS Improvement

133. Over the last few years, there has been debate about whether NHS England and NHS Improvement should merge. A House of Lords ad-hoc committee established to look at the long-term sustainability of the NHS and adult social care recommended that the two bodies should be merged. We ourselves also concluded, in our last report, that a merger of NHS England and NHS Improvement was one of the legislative proposals that was worth considering.¹⁸¹

178 Health and Social Care Committee, [Integrated care: organisations, partnerships and systems](#), Seventh report of Session 2017–19, HC 650

179 NHS England and NHS Improvement, [Implementing the NHS Long Term Plan: Proposals for possible changes to legislation](#), February 2019

180 Royal College of Psychiatrists ([NLN0041](#))

181 House of Lords Select Committee on Long-term Sustainability of the NHS, [The Long-term Sustainability of the NHS and Adult Social Care](#), Report of Session 2016–17, HL 151, April 2017; Health and Social Care Committee, [Integrated care: organisations, partnerships and systems](#), Seventh report of Session 2017–19, HC 650

134. The legislative proposals suggest that NHS England and NHS Improvement should be brought together more closely beyond the limits of the current legislation, whilst clarifying the accountability to the Secretary of State and Parliament. The proposals suggest this would allow the two organisations to go further in:

- speaking with one voice, setting clear, consistent expectations for providers, commissioners and local NHS health systems;
- developing a single oversight and support framework for the NHS that supports integration and the best use of resources;
- bringing together national programmes of work and key activities; and
- using their collective resources more efficiently to support local health systems.¹⁸²

135. It is proposed that this be achieved either by creating a single organisation which combines all the relevant functions of NHS England and NHS Improvement (including Monitor and the TDA), or by leaving the existing bodies as they are, but providing more flexibility to work together, including powers to carry out functions jointly or to delegate or transfer functions to each other, and the flexibility to have non-executive Board members in common. A preference for either option is not specified in the proposals, but both would require primary legislation to achieve. The accountability between the Secretary of State and the organisations would need to be appropriately defined in legislation, if a single body were created.

136. There was general support expressed for the proposal that NHS England and NHS Improvement should continue to be brought closer together, including wide support for creating a single organisation responsible for all the existing functions of NHS England and NHS Improvement. Despite the wide welcome for the proposal, many echoed the view that further detail was necessary and that more clarity was needed around the implications of creating a single organisation. While it was thought that the proposal would be received well within the workforce, caution was expressed about the speed at which any reorganisation would be undertaken. There was also concern that the focus of the reorganisation would be on cost cutting. More widely, the NHS Confederation said:

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.¹⁸³

137. We commend NHS England and NHS Improvement for the efforts they have made to work closer together. However, we are aware that further progress is hampered by the legislation covering the two bodies. In an era of local systems, the NHS at a national level should operate with one voice, so as to avoid any incoherence in the support, guidance and direction local systems receive. We support in principle the proposal to merge NHS England and NHS Improvement into a single body, but await further clarity on the implications of the creation of a single organisation. In particular, we are concerned about the degree of central control that would result from this merger,

182 NHS England and NHS Improvement, [Implementing the NHS Long Term Plan: Proposals for possible changes to legislation](#), February 2019

183 NHS Confederation ([NLN0047](#))

especially in light of the other changes put forward. When these proposals come before us again as a draft bill, one of the issues we will want to consider very carefully is how local autonomy will be protected under the new arrangements.

Functions of arm's-length bodies

138. Arm's Length Bodies (ALBs)—that is, public bodies established with a degree of autonomy from the Secretary of State—play an important role in supporting the health and care system. They include not only NHS England and NHS Improvement but other bodies with crucial roles of their own, such as Public Health England, the National Institute for Health and Care Excellence (NICE), NHS Digital and the Care Quality Commission.

139. NHS England and NHS Improvement have put forward proposals to enable ALBs to act in a more joined-up way. The changes would establish new powers for the Secretary of State to transfer, or require delegation of, ALB functions to other ALBs, and to create new functions of ALBs. Stakeholders have questioned how the Secretary of State might look to exercise these powers, and what protections might be undertaken prior to the use of such powers, for example adequate stakeholder consultation.

140. We would like more clarity on how establishing powers for the Secretary of State to transfer powers to arms-length bodies (ALBs), or require ALBs to delegate their functions to another ALB, will be used to support the delivery of the NHS Long-term Plan and the goal of better integration. The strategic intent behind this power is unclear.

Conclusions and recommendations

Competition

1. We warmly welcome, in principle, NHS England and NHS Improvement's proposals to promote collaboration, especially the proposal to repeal section 75 of the Health and Social Care Act 2012 and revoke the regulations made under it. We believe collaboration, rather than competition, as an organising principle, is a better way for the NHS and the wider health and care system to respond to today's challenges. (Paragraph 29)
2. We heard concerns that NHS England and NHS Improvement's proposals risk deregulating, rather than de-marketising, the NHS without creating an alternative regulatory mechanism. In its response to this report, we request that the Government set out its assessment of the likelihood that the proposed legislation would have the effect of deregulating competition in the NHS and how it intends to ensure patients and taxpayers are protected from any adverse unintended consequences. (Paragraph 30)

Competition and Markets Authority

3. We support NHS England and NHS Improvement's proposal to remove the need for NHS Improvement to refer objections on the national tariff and provider licence conditions to the CMA. No referral has ever been made and the CMA, as a general competition regulator, is not best placed to intervene in these matters. Nonetheless, we share the concerns of providers about the removal of this safeguard altogether and recommend that the Department, NHS England and NHS Improvement build in a mechanism for independent adjudication of challenges to these decisions. (Paragraph 31)
4. We welcome the intention behind removing the Competition and Markets Authority's NHS-specific role in overseeing mergers involving foundation trusts. The CMA's role, we heard, has led to unnecessary cost and duplication for foundation trusts involved in mergers and acquisitions. However, to remove foundation trusts entirely from the CMA's remit would, we heard, require the law to change so that foundation trusts are no longer considered as 'enterprises' under the Enterprise Act. We recommend that the Department, together with NHS England and NHS Improvement, seek legal advice on the changes that will be required to remove foundation trusts from the CMA's jurisdiction and the implications of doing so. (Paragraph 32)

National tariff

5. We support NHS England and NHS Improvement's intention to provide greater local flexibility over the use of the national tariff system. Providing more flexibility will help local providers and commissioners to remove perverse incentives, especially in managing patients with multiple long-term conditions. One of the benefits of a national tariff system is that it has helped to ensure that providers compete on the

quality, rather than the price, of the care they deliver. In its response, we request that the Department, together with NHS England and NHS Improvement, outline how they plan to avoid and/or mitigate the concern that these changes could result in price competition. (Paragraph 41)

Procurement

6. We support the intent behind NHS England and NHS Improvement's proposal to ensure that commissioners can exercise discretion over when to conduct a procurement process. The practice of procurement in parts of the NHS, particularly community and mental health services, has added complexities and costs to the system, with little added value for patients in return, and made it harder for services to integrate. (Paragraph 54)
7. Given the way the NHS in England operates, the proposal to take it out of the Public Contract Regulations 2015 may well face legal difficulties. NHS England, NHS Improvement and the Department need to explore that in detail and be clear about the law, including EU law. In the meantime, however, we recommend that they should explore whether there are more flexibilities within PCR 2015 than are currently being used. (Paragraph 55)

Best value test

8. We recommend that the Department, NHS England and NHS Improvement work with the NHS Assembly to co-produce a 'best value' test. This test should be underpinned by a broad definition of value, with the quality of care and health outcomes at its heart, but also aligned with conceptions of public and social value used by other public services. As the term 'best value' is perceived in local government to be synonymous with cost-cutting, we strongly advise that NHS England and NHS Improvement reconsider the using the phrase 'best value'. (Paragraph 56)

Patient choice

9. We support the intention of NHS England and NHS Improvement's proposals to strengthen patient choice. The evidence we have taken in the course of this inquiry suggests that practical considerations such as geography have a greater influence on the exercise of patient choice than legislation, and that what most patients want is good quality care close to their home. Using patient choice as a lever to improve quality may help for some services, particularly planned or elective care, but as an organising principle, we believe that encouraging collaboration between providers is a much better way to provide good-quality care for patients, especially those with multiple long-term conditions. Nonetheless, witnesses to our inquiry accepted the desirability of maintaining and enhancing patient choice in the NHS. Those developing the proposals should ensure that they do not have unintended consequences that negatively impact on the ability of patients to exercise their right to choose between providers. (Paragraph 63)

10. Having a right to choice relies on that right being enforceable. We recommend that an appeal mechanism is preserved, within an existing independent body, for patients who believe they have been denied choice. (Paragraph 67)

Integrating care provision

11. Integrating contracts and services is not the same as integrating care for patients. Nevertheless, there already exist different contractual and service options, permissible within existing legislation, that help to remove or reduce the barriers which organisational boundaries pose to integration. More work is needed to understand why some services are currently unable or unwilling to make use of these arrangements. We recommend that the National Implementation Plan/ framework should include proposals to increase the uptake of existing contractual options and/ or further extend the ways organisations can work collaboratively. (Paragraph 73)

Integrated care provider contract

12. We welcome assurances from NHS England and NHS Improvement that holders of an Integrated Care Provider contract are expected to be public statutory providers, but with the ability to subcontract with a range of other partners. This proposal would achieve a sensible balance by enabling ICP contract holders to draw on the diverse mix of health and care provision that exists across the country, while ensuring the responsibility entailed in these long-term contracts rests with public statutory bodies. (Paragraph 78)
13. We strongly recommend that legislation should rule out the option of non-statutory providers holding an ICP contract. Doing so would allay fears that ICP contracts provide a vehicle for extending the scope of privatisation in the English NHS. (Paragraph 79)
14. Given the political climate, we recognise that legislation may not be brought before the House of Commons for some time. Until legislation is passed, we strongly urge that ICP contracts should be piloted only in a small number of local areas and subject to careful evaluation and that they should not be held by non-statutory providers. (Paragraph 80)

Creation of new NHS trusts

15. We support the proposal to give the Secretary of State the power to create a new NHS trust to deliver integrated care in an area. This change to the legislation will extend the ways in which local commissioners can integrate health and social care. Our view is that this power must not be used by the Secretary of State to impose a form of integration on local health and care services or as threat to incentivise organisations to collaborate. We recommend that the Secretary of State must not be allowed to exercise this power without a request from the local clinical commissioning group(s). (Paragraph 86)

16. We recommend that a request to the Secretary of State must follow a robust assessment and public consultation to ensure the creation of a new NHS trust is in the best interests of patients and the local population, and represents an efficient use of public money. (Paragraph 87)

VAT rules

17. We recommend the Government's forthcoming review of VAT exemptions on central government should also make recommendations for how VAT exemptions covering the NHS and local government can be protected and/or extended so as to ensure neither body is worse off as a result of integration. (Paragraph 92)

Integrated care systems

Governance and accountability

18. The issue of the accountability of integrated care systems (ICSs) and sustainability and transformation partnerships is very important, and not easily solved in the absence of their establishment as statutory bodies. While we agree that it is not advisable at this time to establish all integrated care systems as separate legal entities, in the absence of formal accountability for their collective decision-making, we expect ICSs to meet the highest standards of openness and transparency in the conduct of their affairs by holding meetings in public and publishing board papers and minutes. Transparency, however, is not an adequate substitute for accountability if it is not clear who should be held to account. It is vital to avoid creating a situation where everyone in the system is accountable, but no-one can be held responsible for important decisions. We recommend that the National Implementation Plan due this autumn should set further directions for the standards of governance and transparency local systems should demonstrate. (Paragraph 104)

Joint committees

19. We agree that the law should change to enable clinical commissioning groups and NHS providers (NHS trusts and foundation trusts) to establish joint committees. (Paragraph 109)
20. We are concerned that the proposals are currently too NHS-centric. Integrated care systems must not repeat mistakes of the past and become unresponsive monopolies or "airless rooms" where non-statutory alternatives are shut out. (Paragraph 110)
21. Local authorities must be part of the decision-making process in order for integrated care systems to be truly place-based and focused on population health. We recommend that additional proposals should be developed that enable local authorities to participate as equal partners in joint committees with clinical commissioning groups and NHS providers. (Paragraph 111)

Triple aim

22. We welcome the proposal to introduce a shared duty that requires organisations that plan services in a local area (CCGs) and NHS providers to “promote the triple aim of better health for everyone, better care for all patients and the efficient use of NHS resources, both for their local system and for the wider NHS.” Nevertheless, the proposal as currently framed is too NHS-centric. The term ‘better health’ was viewed by witnesses, particularly representatives of the voluntary and community sector, as focused on the NHS. Wellbeing, in contrast, was seen as a more inclusive term which reflects the contribution local government and the voluntary and community sector make to people’s lives. Wellbeing is also an intrinsic part of the World Health Organisation’s definition of health. We recommend that the “triple aim” should be rephrased to include a specific reference to wellbeing. (Paragraph 115)

Barriers to system-working: mergers and acquisitions and capital spending limits

23. Local systems should be empowered to decide the most appropriate way to manage NHS resources. This includes being encouraged to resolve disputes between local partners about the best way to manage resources, including capital resources, within the system. There may be circumstances in which national intervention is necessary to ensure one local partner is not, unreasonably, frustrating system-wide efforts. NHS England and NHS Improvement should have powers in reserve for such circumstances, but such powers should be used only as a last resort. (Paragraph 128)
24. We do not, therefore, support these proposals in their current form. If similar proposals are brought before us for pre-legislative scrutiny in the form of the expected draft bill, we will expect to see the proposed legislation specify the limited circumstances in which these powers can be exercised. The design of these powers should focus on a) removing barriers to integrated care and b) empowering and encouraging local systems to resolve disputes over the configuration of services and the management of resources, including capital resources, themselves. (Paragraph 129)

National bodies

NHS England and NHS Improvement

25. We commend NHS England and NHS Improvement for the efforts they have made to work closer together. However, we are aware that further progress is hampered by the legislation covering the two bodies. In an era of local systems, the NHS at a national level should operate with one voice, so as to avoid any incoherence in the support, guidance and direction local systems receive. We support in principle the proposal to merge NHS England and NHS Improvement into a single body, but await further clarity on the implications of the creation of a single organisation. In particular, we are concerned about the degree of central control that would result from this merger, especially in light of the other changes put forward. When these

proposals come before us again as a draft bill, one of the issues we will want to consider very carefully is how local autonomy will be protected under the new arrangements. (Paragraph 137)

Arms-length bodies

26. We would like more clarity on how establishing powers for the Secretary of State to transfer powers to arms-length bodies (ALBs), or require ALBs to delegate their functions to another ALB, will be used to support the delivery of the NHS Long-term Plan and the goal of better integration. The strategic intent behind this power is unclear. (Paragraph 140)

Formal minutes

Tuesday 18 June 2019

Members present:

Dr Sarah Wollaston, in the Chair

Mr Ben Bradshaw	Diana Johnson
Rosie Cooper	Andrew Selous
Angela Crawley	Dr Paul Williams

Draft Report (*NHS Long-Term Plan: legislative proposals*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 140 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Fifteenth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Tuesday 25 June at 2 pm.]

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee's website.

Tuesday 2 April 2019

Professor Katherine Checkland, Professor of Health Policy and Primary Care, University of Manchester, **Richard Murray**, Chief Executive, The King's Fund, **Nigel Edwards**, Chief Executive, Nuffield Trust [Q1–35](#)

Simon Stevens, Chief Executive, **Ian Dodge**, National Director: Strategy and Innovation, NHS England, and **Ian Dalton**, Chief Executive, **Ben Dyson**, Executive Director of Strategy, NHS Improvement [Q36–97](#)

Tuesday 23 April 2019

Dr Amanda Doyle, Chief Officer, Healthier Lancashire and South Cumbria, **Prof Chris Ham**, Chair, Coventry and Warwickshire STP, **Patricia Hewitt**, Chair, Norfolk and Waveney STP, **Jon Rouse**, Chief Officer, Greater Manchester Health and Social Care Partnership [Q98–146](#)

Julie Wood, Chief Executive, NHS Clinical Commissioners, **Chris Hopson**, Chief Executive, NHS Providers, **Niall Dickson**, Chief Executive, NHS Confederation, **Sarah Pickup**, Deputy Chief Executive, Local Government Association [Q147–188](#)

Tuesday 30 April 2019

David Hare, Chief Executive, Independent Healthcare Providers Network, **Professor Sue Richards**, Executive Committee Member, Keep Our NHS Public, **Andrew Taylor**, former Director of Cooperation and Competition Panel for NHS-funded services, **Dr Graham Winyard**, former Chief Medical Officer for NHS in England [Q188–219](#)

Dr Clare Gerada, **Sara Gorton**, Head of Health, UNISON, **Dame Donna Kinnair**, Chief Executive and General Secretary, Royal College of Nursing, **Rob Harwood**, Chair, BMA Consultants Committee [Q220–246](#)

Wednesday 1 May 2019

Christian Dingwall, Partner, Browne Jacobson LLP, **Sharon Lamb**, Partner, McDermott Will and Emery, **David Lock**, Landmark Chambers [Q247–276](#)

Charlotte Augst, Chief Executive, National Voices, **Sir Robert Francis**, Chair, Healthwatch, **Professor Jo Pritchard**, Consultant – Health and Social Care, Social Enterprise UK, **Beth Capper**, Head of Programmes, Richmond Group [Q277–306](#)

Published written evidence

The following written evidence was received and can be viewed on the [inquiry publications page](#) of the Committee's website.

NLN numbers are generated by the evidence processing system and so may not be complete.

- 1 38 Degrees ([NLN0057](#))
- 2 ABPI ([NLN0010](#))
- 3 Academy of Medical Royal Colleges ([NLN0022](#))
- 4 Action on Hearing Loss ([NLN0042](#))
- 5 Action on Smoking and Health (ASH) ([NLN0030](#))
- 6 Action with Communities in Rural England ([NLN0031](#))
- 7 Association of British HealthTech Industries (ABHI) ([NLN0019](#))
- 8 British Medical Association ([NLN0037](#))
- 9 British Red Cross ([NLN0038](#))
- 10 Carers UK ([NLN0025](#))
- 11 Chartered Institute of Public Finance and Accountancy (CIPFA) ([NLN0046](#))
- 12 Chief Executives' Coordinating Group ([NLN0004](#))
- 13 Competition and Markets Authority ([NLN0017](#))
- 14 CQC ([NLN0058](#))
- 15 Department of Health and Social Care ([NLN0044](#))
- 16 Diabetes UK ([NLN0020](#))
- 17 Christian Dingwall ([NLN0061](#))
- 18 The Faculty of Sexual and Reproductive Healthcare ([NLN0005](#))
- 19 General Medical Council ([NLN0026](#))
- 20 Guy, Dr Mary ([NLN0021](#))
- 21 Health Foundation ([NLN0039](#))
- 22 Healthcare Audit Consultants Ltd ([NLN0003](#))
- 23 Healthcare Financial Management Association ([NLN0034](#))
- 24 Healthwatch England ([NLN0049](#))
- 25 IHPN ([NLN0012](#))
- 26 Independent Healthcare Providers Network ([NLN0055](#))
- 27 King's Fund ([NLN0052](#))
- 28 Local Government Association ([NLN0051](#))
- 29 London Borough of Tower Hamlets ([NLN0032](#))
- 30 Londonwide LMCs ([NLN0008](#))
- 31 medConfidential ([NLN0018](#))
- 32 Mind ([NLN0054](#))
- 33 National AIDS Trust ([NLN0016](#))

- 34 NHS Clinical Commissioners ([NLN0043](#))
- 35 NHS Confederation ([NLN0047](#))
- 36 NHS Providers ([NLN0011](#))
- 37 NHS Providers ([NLN0063](#))
- 38 Nuffield Trust ([NLN0009](#))
- 39 Parkinson's UK ([NLN0023](#))
- 40 Parliamentary and Health Service Ombudsman ([NLN0048](#))
- 41 Prof Sue Richards, Keep Our NHS Public ([NLN0053](#))
- 42 RCGP, RCOG & FSRH ([NLN0036](#))
- 43 RCGP, RCOG & FSRH ([NLN0062](#))
- 44 Rethink Mental Illness ([NLN0007](#))
- 45 The Royal British Legion ([NLN0006](#))
- 46 Royal College of General Practitioners ([NLN0013](#))
- 47 Royal College of Midwives ([NLN0029](#))
- 48 Royal College of Nursing ([NLN0014](#))
- 49 Royal College of Nursing ([NLN0045](#))
- 50 Royal College of Physicians ([NLN0027](#))
- 51 Royal College of Psychiatrists ([NLN0041](#))
- 52 Sanchez-Graells, Dr Albert ([NLN0001](#))
- 53 Shelford Group ([NLN0024](#))
- 54 Social Enterprise UK ([NLN0033](#))
- 55 Social Enterprise UK ([NLN0059](#))
- 56 Taylor, Mr Andrew ([NLN0002](#))
- 57 UNISON ([NLN0028](#))
- 58 Unite the Union ([NLN0050](#))
- 59 Vidal, Mr Michael ([NLN0015](#))
- 60 Winyard, Dr Graham ([NLN0056](#))
- 61 Winyard, Dr Graham ([NLN0060](#))

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the [publications page](#) of the Committee's website. The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2017–19

First Report	Appointment of the Chair of NHS Improvement	HC 479
Second Report	The nursing workforce	HC 353 (Cm 9669)
Third Report	Improving air quality	HC 433 (HC 1149)
Fourth Report	Brexit: medicines, medical devices and substances of human origin	HC 392 (Cm 9620)
Fifth Report	Memorandum of understanding on data-sharing between NHS Digital and the Home Office	HC 677
Sixth Report	The Government's Green Paper on mental health: failing a generation: First Joint Report of the Education and Health and Social Care Committees of Session 2017–19	HC 642 (Cm 9627)
Seventh Report	Integrated care: organisations, partnerships and systems	HC 650 (Cm 9695)
Eighth Report	Childhood obesity: Time for action	HC 882 (CP23)
Ninth Report	Long-term funding of adult social care	HC 768
Tenth Report	Appointment of the Chair of NHS England	HC 1351
Eleventh Report	Antimicrobial resistance	HC 962
Twelfth Report	Prison health	HC 963 (CP 4)
Thirteenth Report	First 1000 days of life	HC 1496 (CP112)
Fourteenth Report	Sexual health	HC 1419
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