Position Statement

Implementing the NHS Long Term Plan – a consultation on proposals for possible changes to legislation

The Federation of (Ophthalmic and Dispensing) Opticians – FODO – is the national representative and professional association for community eye health providers, optometrists and opticians in the UK. Our members provide 85% of optical sector activity in the UK, the majority of NHS primary eye care and a growing proportion of UK ophthalmology.

The National Community Hearing Association (NCHA) represents community hearing care providers in the UK. The NCHA works closely with NHS England, local NHS commissioners, the third sector and provider organisations across England in order to secure quality outcomes for people with hearing loss.

FODO and the NCHA welcome the NHS Long Term Plan and believe there is much in it that will be good for patients, the public and the health and care system. We particularly support the emphases on prevention, care built around individuals (not services or institutions), population health, choice, value and moving care out of acute hospitals and closer to home. These are the only ways to meet growing demand resulting from an ageing population and to save both short term and long term costs especially in eye health.

However the proposal to change legislation in response to NHS Long term Plan is not without risks. The FODO's and NCHA's responses to the NHS consultation on proposed changes to legislation will therefore focus on system safeguards for individuals, the public and the 'best value' partners who deliver care for NHS patients.

In our statement below we set out for both FODO and NCHA members our shared position on the proposed changes to legislation and the background detail that will inform our formal responses to the public consultation which closes on 25 April.

Summary

The consultation to change NHS legislation in England includes some proposals which we support such as:

- streamlining procurement rules where this can reduce costs (4,7,8, 12), provided there are sufficient safeguards in place for patients and the taxpayer
- reviewing the NHS payment system - e.g. amending the tariff (18) - so that new reimbursement models can be developed to incentivise high quality care for long-term conditions (e.g. glaucoma and age-related hearing loss) which are growing due to our ageing population, provided NHS pricing principles, which safeguard quality of care, are maintained

- enabling commissioners and providers to agree appropriate local payment arrangements for services from local hospitals in accordance with tariff rules (20). Done well, this should help achieve the NHS Long Term Plan goal of transforming outpatient care which NHS leadership describe as "outdated and unsustainable", shifting millions of annual and avoidable hospital visits into primary and community care settings at the same time as improving quality of care and controlling the rate of growth in NHS expenditure
- powers to establish new NHS trusts to deliver integrated care services across a given area (29), provided the NHS Constitution is adhered to and patients, not institutions, are put at the heart of the NHS
- permitting NHS providers and others to set up joint committees for example to develop clinical services networks, IT or HR systems (48)
- allowing doctors and nurses on CCG governing bodies to be drawn from local providers as GPs are (subject to the same safeguards against conflicts of interest) (53, 54)
- 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 (60)
- enabling CCGs to enter into formal joint decision-making arrangements in respect of delegated functions with neighbouring CCGs or local authorities (to avoid unlawful 'double delegation') (66, 67)
- permitting NHS England and one or more CCGs to commission 'section 7A' services jointly (even though these will cover geographical foot-prints far larger than primary care networks of 30-50,000 population) (70)
- merging NHS England and NHS Improvement (now that NHS Improvement has become the development organisation for NHS Trusts) (77,78), provided there is sufficient independent scrutiny and accountability for the newly formed arm's length entity.

There are some proposals which need much further work to be convincing such as:

- the definitions of 'best value' and accompanying statutory guidance (8,11,14)
- the definition of 'patient benefit', who decides what that is and who can challenge it? (5,16)
- the definition of how an Integrated Care Provider (ICP) "involves the local community" and who decides whether that duty has been delivered (30) when there may not be clear separation between commissioner and ICP (48, 53)
- joint appointments between commissioners and NHS providers at senior levels (other than clinicians) (57).

There are some areas where we feel the case is not yet proven and where retaining existing safeguards might be in the public interest such as:

- removing NHS Improvement's oversight of efficient resource allocation e.g. competition powers) (5). If this is to happen, it would be better for those powers to be preserved and transferred to the Competition and Markets Authority (CMA). This is essential to protect against the emergence of 'too big to fail' monopolies covering primary, secondary and potentially social care, which might compromise quality of care and not provide value for money. This is a concern which the Health Select Committee and other health experts have raised, and which we share
- the ability for providers to be able to apply to NHS Improvement to make local modifications to tariff prices before Integrated Care Systems (which are as yet unproven in term of general benefit) are fully developed and which may take time (23).

Finally, as set out in the NHS Long Term Plan the NHS now needs to transform outpatient care and to achieve this we strongly support extended patient choice to:

1. non-consultation led ophthalmology (eye care) services, most of which are ambulatory, so that patients can access care closer to home without the need to go to hospital for routine eye care and follow-ups, helping reduce millions of visits per year to hospital
2. audiology (adult hearing services) for which there is overwhelming evidence of the benefits. This could help shift more than 2 million outpatient appointments each year into primary and community care settings – including 2 million audiology appointments and 300,000 ENT visits.

We welcome the opportunity to contribute our members' views and commend NHS England's approach to openness and will be reflecting the feedback above in our formal response.

Our comments below provide members with more detail on our position on accountability, contestability, patient choice, best value, patient voice and evidence.

Accountability

The consultation document does not explain how genuine accountability can operate between commissioners (who under the NHS Long Term Plan are to be "streamlined and become leaner, more strategic organisations") and Integrated Care Providers (ICPs) which will have "overall responsibility for deciding how to use resources to improve quality of care and health outcomes for a defined population" (26, 30).

This becomes problematic when an ICP:

- may have "a single contact and combined budget" (24)
- may subcontract uncontestably and at discretion (11)
- may have joint committees (45) and joint appointments (53, 57) with the commissioner
- may include GP services (66)
- may include social care (49) despite the intention for local authorities to retain their powers independently to challenge local NHS plans through Overview and Scrutiny Committees (69)
- is likely to be many times larger and more powerful than the new primary care networks of 30-50,000 registered population.

We welcome the reassurance that joint committees between commissioners and NHS providers will not "do away with existing responsibilities of CCGs and NHS providers"(45) and will not be able to exercise decisions on purchasing services (47) although it is difficult to see how these distinctions can be safeguarded in reality, especially in the light of joint appointments.

On the other hand we agree that it is no longer a sensible or wise use of NHS resources to pit one NHS Trust against another, so to permit joint committees of NHS providers (and others) in order to set up, for example, clinical services or IT networks – just as CCGs can – is sensible.

As too is the proposal to permit local authorities to be part of joint NHS provider committees, for example, to develop integrated pathways across health and social care where this is agreed by all parties. Nevertheless, this does undermine the principle of local authorities being able independently to challenge local health systems through Overview and Scrutiny Committees and to refer a matter to the Secretary of State for Health where the Committee feels that a proposal substantially to vary local health services has not been adequately consulted upon (69). It may be

that these roles have been proven or judged to be ineffective or impossible to operate in a more integrated world. In either case greater explanation would be helpful.

The proposal to permit doctors and nurses on CCG governing bodies to be drawn from local providers just as GPs are (subject to safeguards against conflicts of interest) is sensible as local clinical and patient base knowledge is key to good planning and delivery (53, 54).

However, it is far from clear how accountability could be assured if joint appointments were permitted at senior management level – e.g. at CEO, Finance or Operations Director level. It is difficult to see how this could operate in a way which would reassure the public if the intention is genuinely not to "do away with the existing responsibilities of CCGs and NHS providers" (45). Sometimes the costs of getting this right and of being open to legal challenge may be in the public interest and outweighed by public benefit (56, 57).

Whilst the principle of "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" (60) is unexceptionable, it would be good to know which will become more important when the three aims conflict or in times of financial constraint.

Historically, as the *Five Year Forward View* recognised, prevention and better health for everyone has very much taken third place, whist care has taken second and finance (in recent years) primacy over everything else, even when that has meant patients suffering or not getting the treatment they need in time. The review of metrics and targets may help but it may also lead to an increased risk of hidden rationing which always falls on the weakest in society. We strongly urge DHSC and NHS England to build safeguards against these risks into the legislation.

Traditionally the NHS has striven towards allocating NHS resources to be spent on a given population weighted for age, deprivation, market forces etc on the principle that this was that population's fair share (even though that has never quite been achieved). However, when local system priorities and wider NHS priorities conflict it is not clear how this will be resolved by the new 'triple aim' shared duty (60), how this can be challenged by stakeholders or who will arbitrate. It is also unclear how this new duty will be more effective than the existing "statutory duties [on the NHS bodies and local authorities] to cooperate with one another when performing their functions" (59) and "the extensive freedoms [they already have] to work together jointly, including joint commissioning and budget pooling where this is locally agreed" (69).

This may be loose drafting but, whilst we support the principle of permitting NHS England and one or more CCGs to commission section 7A services jointly to avoid unlawful 'double delegation (even though these will cover geographical foot-prints far larger than primary care networks of 30-50,000 population), this is not the same as permitting CCGs to commission those services as "if they were their own" (67, 73). It is not clear how this would enable NHS England to "keep overall responsibility for these functions" (68) or how the fact of NHS England consulting on plans to delegate functions to CCGs and pool budgets would offer any protection to patients or the public, especially if financial pressures were the driver (68). It would be helpful if these difficulties, and how they might be overcome, were set out clearly for comment before Parliament is asked to legislate.

Contestability

We fully support the aims "to change the NHS for the better and improve services for everyone working in them and using them" and for "local NHS bodies to be free to work together with partners including local authorities, to plan and provide care around patients, not services or

institutions". We would include amongst partners the NHS contractor professions and independent sector partners without whose participation the NHS will not be able to meet population need or achieve its wider goals.

We would make the same point about "other partners" in terms of Integrated Care System (ICS) partnership boards (43). In forward planning ICSs need to take account of all available local capacity, not just that in acute hospitals, to meet population need and their wider goals. For example, without this system-wide approach the NHS will risk wasting scarce resources on building or training new capacity when existing capacity exists. This would not only be a poor use of NHS resources but would also unnecessarily delay care and result in less good outcomes for patients and population health overall.

We agree that "the rules and processes for procurement, pricing and mergers can create unnecessary bureaucracy that gets in the way of enabling integration of care". They can also be costly, bureaucratic and time-consuming for commissioners and providers (both inside and outside the traditional NHS). However, when done well, the NHS's own evidence has shown this can also bring major benefits for patients and taxpayer.

We therefore support the proposals to review

- the CMA's function to review mergers involving NHS Foundation Trusts (4)
- NHS Improvement's competition duties (5)
- the need for NHS Improvement to refer contested licence conditions or National Tariff provisions to the CMA (7).

However, these rules were all originally introduced to protect patients and to ensure taxpayers got value for money from the significant investment in the NHS, so we question why NHS Improvement's competition powers should be removed without introducing an alternative and proportionate safeguard (5). Here, in our view, the CMA should replace them as a pubic safeguard of last resort.

As many of the proposals in the NHS Long Term Plan are untested and unproven (except on a small scale) and the effects on a large scale unknown, we wonder whether it is wise to jettison powers when no-one knows whether they will be necessary or not.

In short, although we support the ambitions in the NHS Long Term Plan we have serious concerns about the lack of proposed regulatory oversight in this consultation. We would strongly support the CMA having a clearly defined role to ensure there is a balance struck between the costs and benefits of some market regulation. For example, it should be possible to report a provider – regardless of organisational form – to the CMA

- about price fixing, 'data gaming' , 'contract gaming' or inflating costs which ultimately impacts on patients by reducing either the volume or quality of care, or both, available to local people, even with a block contract arrangement, or if a provider, because of their size and market power, was able to compromise quality of care below acceptable standards.

Patient Choice

Patient choice is a central tenet of the NHS Constitution (this goes far wider than personal budgets which evidence has shown are not suitable for all patients). We therefore welcome the commitments that "choice will still exist for elective care and money will need to continue to follow the patient accordingly" (18). We support the proposal that the requirements on commissioners

and providers in relation to patient choice will be preserved under separate regulations and that the power to set standing rules for commissioners be explicitly amended to include patent choice rights (13) and that "the preservation of patient choice" will inform decisions on service changes following NHS Trust acquisitions and mergers (36).

We also welcome evidence given by the CEOs of NHS England and NHS Improvement to the Health Select Committee on 2 April which suggests in some cases patient choice might be extended to achieve goals set out in the NHS Long Term Plan. Here we would call on the NHS in England to review the weight of its own evidence and extend the right to patient choice to

1. non-consultation led ophthalmology services, most of which are ambulatory, so that patients can access care closer to home without the need to go to hospital for routine eye care and follow-ups, helping reduce millions of visits per year to hospital
2. audiology (adult hearing services) for which there is overwhelming evidence on the benefits (reference NHS Improvement, NICE, NHS England). This could help shift more than 2 million outpatient appointments each year into primary and community care settings – including 2 million audiology appointments and 300,000 ENT visits.

Best Value

We see the merits in ending of "overly rigid procurement requirements and their replacement by a new best value and stronger protection for patient choice" (8).

Here we agree with the Health Select Committee and call on the NHS to clearly define what it means by 'best value', including what the accompanying statutory guidance contains (14), as this will be key to how the NHS Long Term Plan benefits patients, the public and providers. This issue goes to the heart of the NHS Long Term Plan as the 'best value' test will also be the benchmark against which NHS commissioners or Integrated Care Providers (which may have joint staff and operations) use their discretion to seek to expand capacity from or to transfer services to healthcare providers outside the NHS (11).

It is regrettable that the definition of 'best value' and draft statutory guidance have not been included in this consultation. Consulting on these after new legislation is passed, will mean that Parliament will have to agree wide-ranging legislative change without having the full information before it.

In our view it will be important for the new 'best value' test (and draft statutory guidance) to be defined and consulted on <u>before</u> Parliament is asked agree to legislative change.

Patient Voice

The proposal that NHS Improvement (now the development organisation for NHS Trusts) "should continue to review proposed transactions, including [trust] mergers and acquisitions to ensure there are clear patient benefits" is welcome (5), provided that it is sufficiently resourced to appraise such complex transactions scientifically and objectively and that patients are indeed likely to benefit.

We note that the 'best interests of patients' is also to be a key element in the new 'best value' test which will replace procurement and competition rules (16). Similarly "clear patient benefits" are to be the test of when NHS Improvement can direct NHS Foundation Trust mergers and acquisitions over the heads of Boards and local Trust members (35); and how services are to be changed in such circumstance will also be subject to "stringent tests, including strong patient engagement"(36).

The challenge here therefore is how 'patient benefits' will be defined and by whom? Traditionally they have been defined as general benefits over the effects on individuals but it is not clear how that will operate in the era of care shaped around individual patients, and innovative solutions and care models may need to be found. It is to be hoped that the tests to be applied in future will be set out and consulted on before Parliament is asked approve changes in primary legislation.

Evidence

These proposals are "based on what [NHS England has] heard from patients, clinicians, NHS leaders and partner organisations, as well as national professional and representative bodies" (Introduction). We appreciate the imperative to keep consultations clear and focused, however this evidence, how it was analysed and weighted, is not set out anywhere - not even on the NHS England or DHSC websites as would normally be expected.

It is reported that "some local health systems have expressed interest in…….bringing some services together under the responsibility of a single provider organisation, supported by a single contract and combined budget" (24). Given the magnitude of this proposal and the historical experience of District Health Authorities which were deemed not to have served patients well, it is surprising that this consultation does not provide evidence of which health systems these are, what proportion of all health systems they represent, whether the expressions of interest were unanimous or contested, and what other views (if any) have emerged which might not have been so positively considered.

The consultation reports that "in recent years it has become increasingly common for NHS provider organisations to come together, through mergers and acquisitions, so that a single organisation can plan and deliver service better across multiple sites. This can allow the NHS to manage its resources – its workforce, its buildings and other capital assets, its knowledge and insights – better, for instance by developing standardised approaches to service design and continuous quality improvement, improving approaches to recruiting, retaining and developing staff and sharing back office and clinical support services" (31).

Much of this is undoubtedly true especially in respect of workforce planning, recruitment and management where it was absurd for the NHS to be competing against itself for staff groups in short supply. However the main success criteria identified are managerial and inward-looking and it would have been helpful if the consultation had provided links to hard evidence of examples where mergers and acquisitions have resulted in better care, outcomes and value, as we understand this has not universally been the case in other industries in either the public and independent sectors. The three examples cited date only from 2017 (Manchester University NHS Foundation Trust) and 2018 (University Hospitals Birmingham NHS Foundation Trust and East Suffolk and North Essex NHS Foundation Trust) and so are unlikely yet to provide solid evidence on which to base national policy on this scale.

Given the importance of the new 'best value' test in future commissioning arrangements (8), it would have been helpful for NHS England to have published evidence about how well the 'best value' test has worked for clients in social care since its introduction in that sector, and whether and if so how NHS England's thinking differs from or builds on this.

There is only passing reference in this consultation to local authorities' role, which it is intended they retain, independently to scrutinise and challenge local health service plans through local Overview and Scrutiny Committees. It is not clear whether these arrangements have been proven to be

effective or ineffective. In either case it would have been helpful for links to the evidence base to have been provided.

In our view the evidence to support the proposals put forward in this consultation should be published before Parliament is asked approve changes in primary legislation.

FODO/NCHA
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