

**LGA submission
NHS England
Legislative proposals for the NHS Long Term Plan
Friday 12 April 2019**



Submission

1. About the Local Government Association (LGA)

- 1.1. The Local Government Association (LGA) is the national voice of local government. We are a politically-led, cross party membership organisation, representing councils from England and Wales.
- 1.2. Our role is to support, promote and improve local government, and raise national awareness of the work of councils. Our ultimate ambition is to support councils to deliver local solutions to national problems.

2. Summary

- 2.1. We welcome the opportunity to comment on the proposal for legal changes to implement the NHS Long Term Plan. This response summarises our general views on the overall objectives of the proposals as well as commenting on specific proposals where relevant to our membership. Our primary concern is to identify implications for local government.
- 2.2. Our response draws on the views of local and national health and care leaders. We convened a consultation session of senior local government and NHS representatives in March 2019 to share views with senior representatives of NHS England, the Department of Health and Social Care, and the Ministry of Housing, Communities and Local Government. Our response reflects the discussion between NHS England and the LGA Community Wellbeing Board on the legal proposals.

3. General Comments

3.1. The NHS works within a wider system

3.1.1. Like the NHS Long Term Plan (LTP) itself, the proposed legal changes focus almost solely on measures to enable greater collaboration between NHS organisations. The lack of recognition that the NHS increasingly operates within a complex system involving local government, voluntary and community services and private and independent providers, public health etc. means that there is inadequate consideration of what impact changes to the legal framework for the NHS will have on system-wide working with other partners. In particular, measures to enable greater collaboration between NHS and other partners, including local government, in our view, are not given adequate consideration within the document. The ambitions of the NHS LTP cannot be fully achieved without this important collaboration.

3.1.2. Making it easier for different parts of the NHS to work together is important but we consider that the focus should be on creating a legal framework that facilitates more effective cooperation and collaboration across the whole health and care system, including councils, the community and voluntary sector and people in the

For further information, please contact:
Alyson Morley, Senior Adviser
Email: alyson.norley@local.gov.uk Tel: 0207 664 3230
Local Government Association Company Number 11177145

community rather than just between NHS organisations. It is important that in making legal changes to enable better collaboration between NHS organisations, the Government does not create a two-tier system which inadvertently introduces more barriers to collaboration between the NHS and local councils than currently exist.

- 3.1.3. It is crucial also that the Government includes in any legislative reform measures to remove barriers to local government leadership of integration care arrangements undertaken through the new Integrated Care Provider (ICP) contract. Under the contract councils can neither be lead commissioners nor lead providers. It is important to note that some councils already take a lead commissioner role, for example in commissioning learning disabilities care and support. The LGA believes that the ICP contract should be an transformative, enabling and adaptable vehicle that can flex to fit the future health and care environment as it develops over the next two, 10 and 20 years. The restrictions on the role played by councils as partners in an ICP contract lead us to conclude that it is not the best vehicle for integration and inconsistent with the emphasis on integration of health and social care in order to ensure sustainability of the health and care system.
- 3.1.4. To avoid creating new barriers, we need a common set of legal duties and powers with regard to integration and collaboration that apply equally to the NHS and local government. These should build on existing effective duties on local bodies to integrate services and improve local people's health and wellbeing. It is vital that such proposals are jointly developed and owned by the whole health and care system through partnership with local government and others and we stand ready to play our part in that.
- 3.1.5. The LGA notes that involvement of local government in STPs and ICSs has been highly variable. In some areas, it has been limited but in others there is a growing move to have meaningful involvement. For example, in one ICS area there are two representatives from each council on the ICS board in order to ensure a comprehensive approach to health, care and wellbeing at system level. While this is not a matter for legislation, we would urge the NHS to follow good practice and ensure that local government is included as a full partner in leading system-wide change.

3.2. Make the most of existing legal powers and duties

- 3.2.1. We recognise that there is widespread dissatisfaction within the NHS with many provisions in the Health and Social Care Act 2012. However, it is also important for the NHS to acknowledge and build on some of the positive aspects of the 2012 Act, notably the creation of health and wellbeing boards (HWBs). HWBs are a unique development in the governance of health and wellbeing, bringing together political, clinical, professional and community leaders to develop a shared view of the health and wellbeing challenges and a shared priorities to improve local people's health and wellbeing. Furthermore, even though they are formally a committee of the council, they are like no other local governance body, with elected members and officers, councils and NHS, representatives of statutory and local Healthwatch as equal partners.
- 3.2.2. We are concerned that the leadership role of HWBs is not recognised in these proposals. The evidence from leading health and care systems, including ICSs, is that HWBs strengthen the shared narrative and democratic leadership needed to drive forward change. The strengthened transparency and accountability requirements in the ICP contract similarly echo the power and duties on HWBs.
- 3.2.3. To be effective, the legal reforms need a clear narrative for all partners to fully understand their purpose. This must include a commitment to making the most of the powers and duties of HWBs and explaining how they will fit into the health and care system envisaged by the LTP, which includes integrated care systems (ICSs). The lack of reference to HWBs in the consultation document breaks the critical links

around place and diminishes the role of councils within local health systems strategically and operationally, flowing from ICS at the strategic level and primary care networks (PCNs) at the neighbourhood level. We are keen to work with the Government and NHS England to develop a clear evidence-based narrative which builds on the continued importance of HWBs and how they can work effectively with ICSs and PCNs.

3.2.4. Existing integrated working is built around the duties, created in the 2012 Act, on HWBs, local authorities and CCGs to collaborate to integrate and improve the health and wellbeing of residents. We encourage the legal reforms to build on these duties to create a shared duty across all local partners to collaborate to deliver integration and improve health and wellbeing. This would also reflect the direction taken through the ICP contract, which mirrors these duties in contractual powers and responsibilities on the ICP lead provider. It would be a missed opportunity not to unify proposed reform with existing duties.

3.3. Build on what works locally

3.3.1. We support the intention of the proposed legal changes to encourage and facilitate greater collaboration and integration. It will be important that change is facilitative and enabling, allowing local areas to build on the collaborative working that already exists, rather than replacing existing integrated arrangements with new mechanisms or prescriptive arrangements, which can be barriers to progress. For example, many areas have already begun joining up at strategic level - similar to expectations in the LTP with regard to the development of ICSs - and devolving some commissioning and service provision to the neighbourhood level - similar to LTP expectations regarding PCNs. We are pleased, therefore, that there is no intention to implement a national blueprint for neighbourhood, place and system planning and provision by putting ICSs or PCNs on a legal footing. We hope that this will ensure that areas have flexibility to develop their own neighbourhood, place and system wide approaches to meeting the triple objectives of the LTP.

4. LGA key tests

4.1. We have provided comments on specific proposals in sections a – j below with regard to the potential impact for local government. However, it has been difficult for us to fully identify all the potential impacts as the proposals focus on changing the legal framework for the NHS.

4.2. We have developed four tests to ensure that there is sufficient consideration of the impact on local government, with the aim of creating a level playing field for local government and NHS partners. Our four tests are outlined below.

4.3. We urge the NHS to apply these tests to each of the proposals. We will also be writing to the Secretary of State for Health and Social Care to request that he apply the tests in considering the final proposals put forward by the NHSE.

4.3.1. **Is the proposed reform facilitative and enabling?** Does the proposal enable and facilitate flexibility for system-wide working or does it introduce constraints, in particular between the NHS and local government?

4.3.2. **What is the impact on local government?** What impact will the proposal have on councils in relation to their ability to collaborate with the NHS (and vice versa)? In attempting to improve collaboration within the NHS do the proposals, in effect, create a parallel and different legal framework? Is there any reason why equivalent freedoms, flexibilities and duties proposed for the NHS cannot also be extended to local government? If not, what additional legal reforms are necessary to extend equivalent freedoms, flexibilities and duties to local government?

4.3.3. **Does the proposal promote subsidiarity and transparency in decision-making?** Does it ensure that decisions will be taken at the most local level possible?

We recognise that different services require different planning and delivery footprints in order to reflect economies of scale for specialist services, as well as variation in local need and circumstances. Does the proposal ensure that there is sufficient local transparency and accountability of decision-making on health, care and wellbeing? Furthermore, do existing democratic structures - in particular the health and wellbeing board and health overview and scrutiny arrangements - have sufficient oversight and influence?

4.3.4. Does the proposal build on existing legislation to encourage collaboration?

In particular, does it make the most of existing legal powers and duties in relation to health and wellbeing boards, councils and CCGs to promote collaboration and integration, and improve health and wellbeing?

5. Comments on specific proposals

5.1. There would need to be a national conversation about the various models for applying a levy, both in terms of where and to whom a levy would be applied and how it would be collected. The various options and their impacts would have to be carefully considered in order to identify any potential difficulties in line with the principles set out above.

a. Promoting collaboration

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

The LGA supports the overall objectives to provide a better balance in the NHS between competition and collaboration. These proposals seem reasonable in reducing unnecessary reporting and review requirements. That said, we need to ensure that there is sufficient transparency, accountability and challenge in the system at local level to ensure that decisions are in the best interests of local communities. We support the direction of travel in the ICP contract, in terms of increasing transparency and accountability to partners and the public, and advocate further strengthening the role of HWBs within these arrangements.

We propose a broader public interest test to ensure that any changes are in the public interest but also have no negative impact on the planning and provision on other public services, for example on funding for adult social care or public health services.

b. Getting better value for the NHS

- Revoke regulations made under section 75 of the Health and Social Care Act 2012 and repeal powers in primary legislation under which they are made, subject to a new best value test.
- Remove arrangements between NHS commissioners and NHS providers from the scope of the Public Contracts Regulations, subject to a new best value test.

The LGA broadly supports the proposal to introduce a duty of best value for the NHS. We would be keen to work with the Government and the NHS to develop clear guidance on the operation of 'best value' within the NHS to ensure that it is consistent with equivalent best value duties for local government and learns from councils' extensive experience in this area. It will also be important for guidance to outline how local communities can be assured that the NHS has secured best value, and of the role of HWBs and health overview and scrutiny in providing assurance.

The LGA notes that the proposed exemption from the Public Contract Regulation applies only to the relationship between NHS commissioners and NHS providers. While the LGA supports this, it is important that this, in turn, does not exclude non-NHS providers from opportunities in an unfair way. For this reason, the best value test will be especially important to areas of health care and support that could be provided by non-NHS providers.

The NHS will need to work with local government, the voluntary and community sector and private and independent sector to ensure that they are not excluded from bidding to provide health and care services.

With regard to joint commissioning arrangements between the NHS and local government, local councils are subject to the Public Contract Regulations. We would be concerned if this difference created a barrier to existing or new joint commissioning arrangements, or if commissioning was inappropriately channelled through the NHS.

c. Increasing the flexibility of national NHS payment systems

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

The LGA is in favour of proposals that support greater local flexibility between commissioners and providers, including non-NHS providers. This local flexibility should not be undermined by widespread interpretation around the national formula or the 'power for national prices to be applied only in specified circumstances'. We would welcome clarification that local price setting should be the norm, with the national formula providing guidance, not prescription, for local commissioners. We would also welcome guidance on the involvement of non-NHS bodies in local price setting – in particular local government. Guidance will need to ensure that in setting local tariffs, commissioners and providers, are ensuring choice and best value.

e. Integrating care provision

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

We support this new power for the Secretary of State, though in coming to a decision, the Secretary of State will need to seek the views of local communities and councils on whether the creation of a new trust will lead to better health and wellbeing outcomes, better care and support services and better use of public resources. Furthermore, there will need to be clear assurances that new trusts will be locally accountable for their outcomes, services and use of resources. We would welcome legal reform creating statutory duties which mirror the existing contractual powers and responsibilities in the ICP contract around improving population health and delivering integration, and aligning these with the existing duties on HWBs, local authorities and CCGs to do the same.

It will also be important to ensure that the creation of new large trusts with a wider range of functions does not unbalance the local health and care system, with integrated care trusts becoming 'too big to fail' or over-dominant in a local system. The best value and choice tests will still need to be met by new trusts, and it is critical to ensure clear robust transparency and accountability to local communities.

f. Managing the NHS's resources better

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

We understand the intention of the first proposal is to intervene when local trusts cannot agree to mergers but the LGA has concerns that this power is top-down and directive. Instead, we would want to build on the existing powers of HWBs and council overview and scrutiny of health to help local health commissioners and providers come to a consensus in the best interests of local health and wellbeing outcomes, better care and support services and better use of public resources.

We are also concerned that such mergers, though not a ‘significant variation in services’ in themselves and therefore not subject to formal consultation processes, are often a precursor to ‘significant variations’. Once NHS trusts are merged, this inevitably leads to a reconfiguration of services. Instead of NHSI being granted additional powers to enforce mergers, we propose that HWBs and council overview and scrutiny must be involved in proposals to merge NHS trusts, including disputed proposals. Furthermore, any merger proposals must formally consider the impact on integration with adult social care services or wider council, voluntary and community services where applicable.

g. Every part of the NHS working together

- Enable CCGs and NHS providers to create joint committees.
- Give NHS England powers to set guidance on the formation and governance of joint committees and the decisions that could appropriately be delegated to them.
- Allow the designated nurse and secondary care doctor appointed to CCG governing bodies to be clinicians who work for local providers.
- Enable CCGs and NHS providers to make joint appointments.

The LGA considers that it is rational and reasonable to enable NHS organisations to work together in ways that are consistent with the Section 75 Health Act flexibilities that enable the NHS to work with local government. It would also aid partnership working if the barriers to council membership of CCG boards were removed.

We welcome the proposal in section 49 that NHS England will work with local government to look at how existing provisions for joint working under section 75 of the NHS Act 2006 may be improved, including “the ability for local authorities to be part of joint committees with NHS commissioners and providers where this is locally agreed by all parties”. We would suggest that this should be recognised in legislation so that NHS providers, CCGs and local government can together form joint committees.

Without ensuring equality of powers and duties across councils and the NHS, the provisions to increase collaboration between NHS organisations may lead to a two-tier approach to integration in which collaboration between NHS organisations is easier or given greater priority than collaboration between the NHS and other parts of the system, in particular local government. We would welcome guidance to NHS organisations that joint working within the NHS should not replace joint working between the NHS and local government. Furthermore, joint committees created under new legal powers need to be locally accountable, with clear lines of accountability to and from HWBs.

h. Shared responsibility for the NHS

Create a shared duty for all NHS organisations to promote the ‘triple aim’ of better health for everyone, better care for all patients, and efficient use of NHS resources, both for their local system and for the wider NHS.

We support a new duty on the NHS to promote collaboration. In particular, we support this duty requiring sustainability and transformation partnerships and ICSs to engage with HWBs to develop local plans to reshape and integrate health and care services that are genuinely locally agreed.

We encourage this duty to be merged with the existing corresponding duties on HWBs, councils and CCGs. The LGA has long supported such a duty which we argue will strengthen local partners' shared purpose and action to improve the health and wellbeing of local populations. We would expect this duty to include a requirement to engage partners in the development of local implementation plans and, for HWBs to have a clear role in every ICS. We note again that the ICP contract includes similar contractual powers, which legal reform could strengthen.

i. Planning our services together

- Enable groups of CCGs to collaborate to arrange services for their combined populations
- Allow CCGs to carry out delegated functions, as if they were their own, to avoid the issue of 'double delegation'.
- Enable groups of CCGs to use joint and lead commissioner arrangements to make decisions and pool funds across all their functions.
- Enable NHS England to jointly commission with CCGs the specific services currently commissioned under the section 7A agreement, or to delegate the commissioning of these services to groups of CCGs.
- Enable NHS England to enter into formal joint commissioning arrangements with CCGs for specialised services.

We support measures to enable CCGs to collaborate with each other and with NHS England, and to use joint and lead commissioning arrangements to make decisions and pool resources. Again, we urge CCGs in exercising such powers to involve local government, in particular adult social care and public health, in order to ensure joined-up, person-centred care and support services, which are accountable both to local people and to their democratic representatives.

With regard to enabling joint commissioning of section 7A services, more effective options may be to transfer section 7A responsibilities to CCGs or for local government to have greater powers to hold NHSE more strongly to account or to include local government more in commissioning decisions. The proposals do not give enough information on the proposed costs and benefits of all the options so we would argue for NHSE to work closely with public health commissioners to identify which options would be most effective in improving the commissioning of section 7A public health services and to consider devolving responsibilities to local authorities.

j. Joined up national leadership

- Bring NHS England and NHS Improvement together more closely, either by combining the organisations or providing more flexibility for them to work closely together.
- Enable wider collaboration between ALBs.

We support the commitment of the NHS national arms-length bodies to ensure the most effective use of public resources. We understand that this is the rationale for the proposals to combine the organisations or enable them to work more closely together. However, we want a similar commitment that any consolidation at national level leads to more streamlining and join up locally. Furthermore, the NHS national arms-length bodies must consider what impact any changes would have on transparency and accountability of NHS decision-making at a local level, with an emphasis on devolving decision-making to the most appropriate local level, in order to promote the principle of subsidiarity.