April 2019

## Consultation Response

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

This submission is a general response to the consultation published by NHS England on 28th February.

Because our interest is somewhat generic, and not all of the legislative proposals are relevant to us we prefer to respond in a single document rather than to complete the survey.

We are grateful to NHS England for providing additional information and guidance at a workshop for the voluntary sector on 8th April 2019, with the Richmond Group, Age UK and National Voices.

## About National Voices

National Voices is the coalition of 160 charities that stands for people being in control of their health and care. With our members, we focus on promoting and encouraging person-centred care.

National Voices gave written and oral evidence to the Inquiry of the House of Commons Health Select Committee into integrated care in 2018, and spoke at the launch of its report. Our chief executive will provide further oral evidence to the committee in early May 2019.

National Voices has a strong interest in 'integrated' care, which we helped the national bodies to define as 'person centred coordinated care' in their 'Shared Commitment' document of 2013.

## Questioning the sole focus on the NHS

At this point, the proposals are distinctly NHS-focused. As such they do not seem designed to incorporate many of the goals or concerns of the people with whom the NHS must collaborate to achieve integrated care.

Through this consultation, the select committee enquiry and the eventual process of primary legislation, all stakeholders will be seeing to gain recognition of their interests and needs.

As there is little likelihood of early legislation, this is an opportunity for NHS England to continue working with its partners in open dialogue and a spirit of collaboration, to ensure the proposals take account of all interests.

## Comments on the NHS England proposals as a whole

*Scope*

The legislative proposals use a 'light touch' approach to updating the 2012 Act in order to facilitate better integration of health and care at various levels. This is intended to keep pace with the way that new organisational forms have developed, and the sharing of responsibilities and accountabilities has shifted, since the Act was completed.

National Voices supports these intentions and recognises all stakeholders (including our members) would prefer to avoid significant restructuring of the NHS.

However, any new primary legislation needs to work effectively for everyone – including patients, service users and carers, and the voluntary, community and social enterprise (VCSE) sector.

This is particularly important following the NHS Long Term Plan, whose goals can only be achieved through the full engagement of people who use services (for example, in the 'new service model'), and through active partnerships with non-statutory groups and organisations. The latter can help to achieve prevention, reduce health inequalities, and secure better outcomes through population health management.

The Long Term Plan makes many references to the VCSE sector's role, including specific promises that the sector will be involved in, for example:

- the STP/ICS partnerships;
- the development of meaningful measures of integration;
- the design and delivery of some of the key clinical programmes;
- the design and delivery of the comprehensive model for personalised care; and
- the work of the new primary care networks.

Our sector's experience is that previous plans have included such commitments, but that it has proved difficult to translate those into meaningful changes in practice.

If primary legislation is to be reopened it is therefore a useful question to ask how it might explicitly address the interests of our sector and of people who use services.

Our approach to these matters is informed by The Joint VCSE Review Action Plan. More information on the review and its action plan, to which NHS England is a signatory, is included in the Appendix.

*Outcomes and impact*

It is often assumed by the NHS, especially by commissioners, that the VCSE sector is 'just another group of providers', who are interested in securing funding through commissioning[1]. In this mind-set, it would be the proposals on reducing the role of competition in provision that might interest our stakeholders.

In fact, the sector is broad, diverse and carries out a range of functions, of which the direct provision of services is a relatively small part. Most charities (including those which are engaged in developing services) know they can only have limited direct impact, and wish their larger contribution to be felt in changing types and patterns of statutory and non-statutory health and care, so that they better serve the needs of people.

National Voices would want any new arrangements for NHS bodies to help enable four aims, as steps towards better care and outcomes:

- Shared leadership – partnership in governance and planning – so that the VCSE sector in a 'place' can influence future directions as an equal partner;
- Patient and public voice – so that people locally can influence the planning and shape of their services, often enabled by VCSE groups and organisations;
- Co-design of services – so that the sector can contribute its significant experience of individual and community needs, and what works best to meet them; and
- Equitable commissioning – so that where VCSE sector groups and organisations can contribute positively to service provision, alone or in partnership, there are effective arrangements to include, develop and support them.

We know from experience that statutory duties, regulations and guidance do not necessarily have the desired effect on the 'culture' of health and

[1] Commissioner Perspectives on Working with the Voluntary, Community and Social Enterprise Sector, King's Fund, 2018 https://www.kingsfund.org.uk/publications/commissioner-perspectives-voluntary-community-social-enterprise-sector

care (such as the attitudes, behaviours and processes inherent in NHS organisations and managerial and professional staff).

However, legislation can sometimes help to give force to commitments that otherwise may be neglected.

Our view is that other types of enabling action to engage people and communities suffer from too little attention. For example:

- there is limited work being done on the best methods to involve the VCSE collectively in STPs/ICSs;
- the commissioning system in general does little to ensure the timely involvement of the VCSE sector in planning and redesigning services;
- there is a lack of frameworks or incentives to encourage commissioners actively to develop community assets as part of health and care provision in a 'place';
- there is little 'modelling' of forms of contract that might be more equitable for VCSE sector stakeholders, such as 'alliance contracting';
- VCSE sector 'infrastructure' organisations nationally and locally have shrunk in the last five years, with their funding cut both by the Department of Health and Social Care and by local authorities, severely weakening the capacity of the sector to organise itself, 'broker' its collective contributions to health and care with statutory organisations, engage in shared leadership or develop community groups to the point that they can participate in provision; and
- although the Long Term Plan expects much more from the VCSE sector, particularly in contributing to 'social prescribing', there is no clear way for resources to transfer into the VCSE sector to achieve those expectations.

New legislation will create a dilemma for our sector. Do we accept that primary legislation may not be the best place to 'solve' our priorities, but risk that no other supporting action is taken? Or do we invest in trying to shape the legislation as a lever for change, but take the risk that any new law may be ineffective or burdensome?

## Comments on specific sections of the NHS proposals

### *'Getting better value' and competition policy*

This section proposes reducing the effect of competition policy on NHS procurement, as it can prevent the NHS and other organisations acting in an integrated way to provide services. Section 75 of the 2012 Act would be revoked, the associated powers repealed, and commissioners would instead apply a 'best value test' to judge whether to commission NHS or other providers.

It is not clear what impact this might have on VCSE sector providers, and further joint work on its implications would be useful.

Many of the charities that are currently commissioned do not provide services as an alternative to NHS providers: they provide additional services that add value. Such services may well survive a 'value' test of this nature.

The 'best value test' is not fully explained in the section, making it difficult for us to take a view on it. More work is needed.

One risk is that, rather than simplify commissioning, it could generate burdensome bureaucracy as commissioners must 'prove' best value was obtained.

A further question is who applies the test. In other contexts, value tests are applied by a separate body in order to judge whether a statutory organisation is using public money wisely and managing its market responsibly: for example, Ofcom applies a 'public value test' to the BBC's proposals for service change. Is the proposed 'best value test' intended to be used for self-monitoring or for regulatory/accountability purposes?

It is conceivable that a value test may be useful to our sector *if* it can incorporate notions of 'public value' and 'social value'.

National Voices explored these concepts in relation to integrated care in a discussion paper for the Realising the Value programme[2].

'Public value' means not just making paternalistic decisions as public service managers, but responding to 'what the public values' through close engagement with the communities served.

'Social Value' would mean that, in addition to 'value for money', commissioning decisions should achieve social, economic and environmental value to the local 'place' (for example, through employment, local purchasing, reduced transport miles or the development of community assets).

The Social Value Act 2012 was explicitly intended to make it more likely that smaller, more local and non-statutory organisations might access public

[2] New Approaches to Value in Health and Care, Redding D, Nesta/The Health Foundation, Realising the Value 2016 https://www.health.org.uk/sites/default/files/RtVNewApproachesToValue.pdf

commissioning; but most health commissioners have low awareness of it, and few have used it proactively[3].

This new section seems to assume that commissioning decisions are an 'either/or' – either an NHS organisation, or an alternative provider. There is no consideration of other methods such as alliance contracting or the use of other organisational 'vehicles' to bring a mix of providers under one contract.

Proactive work on such methods, with an explicit aim to enable equitable access for VCSE organisations, would go some way to reassuring the sector that there is a pathway to commissioning available and that duties in primary legislation are not required.

### *'Integrating care provision'*

This section suggests that existing legislation makes it difficult for NHS organisations in a local area to come together to form a new integrated care provider, for example by taking up the new 'Integrated Care Provider' (ICP) contract. The Secretary of State should have a new power to set up new NHS trusts for this purpose.

National Voices and its partners did a lot of work with NHS England on the form of the new ICP contract in order to ensure it would specify requirements for personalised care (anticipating the 'comprehensive model') and be community engaged (citing the NICE guideline on community engagement). We would therefore be content for the new contract to be taken up.

It is not entirely clear to us what the problem is, which a new power for government could resolve.

It seems contradictory to argue that 'integrated' care requires a new NHS organisation, mandated by the Secretary of State, to become the contract holder and lead provider. The preference of many stakeholders for the organisation taking up the ICP contract to be publicly not privately owned, is not seem the same thing as saying it must be 'NHS owned'.

The spirit of integrated care should be that providers from different sectors, including different parts of the public sector, work in collaboration. Some of the charities we work with perceive there to be a risk that the NHS is closing the shop and shutting out its potential partners.

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[3] Healthy Commissioning: How the Social Value Act is being used by Clinical Commissioning Groups, National Voices and Social Enterprise UK, 2017 https://www.nationalvoices.org.uk/publications/our-publications/healthy-commissioning-how-social-value-act-being-used-clinical

Lead provider models can be as exclusive of the VCSE sector as competitive tendering. Without mitigating action, lead providers might resist sub-contracting to VCSE organisations, with whom they are unfamiliar and who often need partnership support to play their role.

Again, it seems there is a need for NHS England to do further work to explore other options for organisational forms to take up the ICP contract. It should explore with its partners: a) which forms of organisation might best secure inter-sectoral collaboration, and b) which other enabling actions might be necessary to make these effective (such as the commissioner, rather than a 'lead provider', shaping the membership of the organisation/consortium and the share of the contract income that should go to the collaborating partners).

### *'Every part of the NHS working together'*

This section typifies the approach taken to preparing the legislative proposals. It is contradictory to base a proposal for 'integrated care', especially as it becomes increasingly place-based and population health focused, only on getting parts of the NHS working together, rather than all necessary contributors to the collaborative approach.

Under the Long Term Plan, shared leadership and collaboration for population health outcomes is supposed to happen at STP/ICS level.

The legislative proposals here stop short of suggesting that ICSs become constituted as a new kind of organisation; but offer no alternative way to ensure that ICSs are accountable, transparent bodies, engaged with the populations they serve.

Nor do the proposals offer a way to ensure, consistently, the full participation of the VCSE sector in ICSs, although this is promised in the Long Term Plan.

As the select committee heard in our evidence to the integrated care inquiry, in their first year the STPs had little engagement with their local VCSE partners. Subsequently there was some improvement , but it can be variable and inadequate. STPs/ICSs now usually engage their local Healthwatches and typically a small number of larger voluntary organisations – which can be perceived by other VCSE organisations as divisive or unrepresentative.

Again, NHS England could mitigate sectoral concerns here by developing plans to make VCSE engagement more consistent and comprehensive, possibly minimising the need for the primary legislation to enforce that.

The consultation document proposes a further set of new 'joint committees' between CCGs and NHS providers, with another vague promise of VCSE involvement. It is hard to be enthusiastic about adding further committees to an already complicated picture.

*'Shared responsibility for the NHS'*

This section proposes that NHS collaboration would be better enabled through a new shared duty for all NHS orgs, based on the 'triple aim'.

We question whether such a duty is appropriate to the goals of integration. The reference is once again to NHS organisations working together, not to wider partnerships. The language of the 'triple aim' is healthcare-specific,for example by referring to 'patients' not people/citizens/residents, and will be perceived by other partners to refer to concerns of the NHS 'silo'.

If there is to be a new duty in law to enable collaboration for integrated care, then it should use a formulation, and reference **outcomes**, to which all local stakeholders can subscribe.

We would further suggest that common outcomes/language can be found in the concept of 'wellbeing'. Local authorities, in the way they provide adult social care, are now driven by a duty that does not reference services or 'care quality', but focuses on the wellbeing of their community (Care Act 2014). The VCSE sector, which helped the government to formulate that duty, could similarly sign up to wellbeing as a common aim: most local VCSE groups and organisations do not 'provide health services', but do contribute to people's wellbeing.

The Joint VCSE Sector Review to which NHS England is a signatory calls for wellbeing to be '[embedded] as a core outcome for both health and social care systems' (see Appendix).

For a discussion of the importance of framing common outcomes for the whole integrated care system, see our value discussion paper[4].

Please contact National Voices' Director of Policy, Don Redding, if any further clarification is required on the contents of this consultation. His email is Don.Redding@nationalvoices.org.uk.

[4] New Approaches to Value, ibid

# Appendix: the Joint VCSE Sector Review

The Joint VCSE Sector Review, initiated in 2014, was a consensus-building process between the sector, the Department of Health, NHS England and Public Health England, that resulted in a set of proposals that would better enable the sector to contribute to health and care provision and outcomes. It reported in May 2016[5]; and NHS England committed to implement the proposals.

In May 2018 the review group updated the process by publishing a revised and refined Action Plan[6].

The Action Plan outlined two key system shifts which would take commissioning and planning closer to communities through working with the organisations closest to the those communities.

1. The shift towards **co-designing** health and care systems with citizens and communities, through working with community-rooted organisations which can reach and engage citizens from all parts of local communities.

That first shift would lead us to redesign health and care services to be more personalised and to focus on building wellbeing and resilience. This would lead to the second shift.

2. A **bigger, strategically-resourced role** for those VCSE services which demonstrate they can provide support which thinks and acts whole-person, whole-family and whole-community.

Three key actions were identified to achieve these shifts:

- Define and measure **wellbeing**, building on existing work to embed it as a core outcome for both health and social care systems and demonstrating the links between achieving health and wellbeing, and the bottom line for local public service economies.

- **Co-design** health, care and public health systems with local people: particularly with those who make most use of health and care services, and with those groups and communities who are most excluded from those services.

- Develop and test new models which **enable commissioners to invest in** and reward the successful creation of wellbeing and resilience.

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[5] Joint review of partnerships and investment in voluntary, community and social enterprise organisations in the health and care sector, DH, 2016
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/524243/VCSE_Investment_Review_A.pdf

[6] The Joint VCSE Review Action Plan, 2018,
https://voluntarycommunitysocialenterprisereview.files.wordpress.com/2019/03/joint-vcse-review-action-plan-2018.pdf

These include models like social prescribing which attempt to bring statutory resources into small community organisations, in ways which work for statutory budget holders, and for civil society.