Royal College of Anaesthetists' response to consultation *Implementing the NHS Long Term Plan - Proposals for possible changes to Legislation*

About the Royal College of Anaesthetists

- Sixteen per cent of all hospital consultants are anaesthetists making anaesthesia the single largest hospital specialty in the UK[i,ii,iii]
- Anaesthetists play a critical role in the care of two-thirds of all hospital patients[iv] and 99% of patients would recommend their hospital's anaesthesia service to family and friends[v]
- With a combined membership of 22,500 fellows and members, representing the three specialties of anaesthesia, intensive care and pain medicine, we are the third largest Medical Royal College by UK membership.

Should you have any questions on this response, please contact Elena Fabbrani, efabbrani@rcoa.ac.uk or by phone on 020 7092 1694.

Introduction

The Long Term Plan sets an ambitious course for the NHS and we welcome the aim of this consultation to amend legislation which creates barriers to the integration of services.

The RCoA has supported better integration of services since the inception of the 44 STPs outlined in NHS planning guidance published in December 2015.[vi] The King's Fund noted that the development of STPs and their underlying goals represented '…a decisive shift from the focus on competition as a means of improving health service performance in the Health and Social Care Act 2012'.[vii]

We believe that the RCoA's initiatives in perioperative medicine[viii], providing a clearer pathway of care from the moment the patient is considered for surgery until they have fully recovered, can provide better patient care, shortened hospital admissions and improved efficiency in the provision of elective surgery. [ix]

Perioperative medicine closely aligns with the goal of enabling better integration across health and social care systems and we support legislative changes which facilitate this.

Specific comments on the proposals

1. **Promoting collaboration. This includes the following proposals:**
    - **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**

An analysis by the King's Fund[x] reveals that the Competition Market Authority can create delays because of its role in examining whether a merger involving a foundation trust will reduce competition, although there is no evidence that it has blocked mergers so far.

Clarification is required on the status of Foundation Trusts and whether they are private (and hence subject to CMA rules) or public bodies. It is our view that they should be subject to other constraints imposed on public bodies (such as recognition of national contracts for terms and conditions of service and Royal Colleges representation on Advisory Appointments Committees). If this is a move in the direction of restoring Foundation Trusts to the status of public bodies like non-Foundation Trusts, then we support this move to remove that artificial distinction. It is sensible to clarify the law around the role of the CMA in the approval of mergers, licence conditions and national tariff provisions as stated in the consultation proposals.

We support the consultation's proposals for the CMA to retain its powers to investigate infringements in competition law for transactions of pharmaceutical products and private companies operating in the health and care sector, so as not to open up loopholes in competition law, which could result in reduced benefits to patients and the NHS.

2. **Getting better value for the NHS. This includes the following proposals:**
    - **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**

Proposals for revoking section 75 of the Health and Social Care Act 2012 and replacing them with a best value test seem sensible. For example we are aware that there is an expectation to engage with expensive private auditing and financial firms in procurement processes. A clear and easy to use 'best value test' could result in considerable savings if reliance on professional services firms could be reduced.

For this to work in practice the 'best value' element in the proposed test needs sharper definition. We would suggest that the definition includes reference to 'strengthening the NHS by utilising existing NHS resources before outsourcing'. If outsourcing is required then the test needs to ensure that contracts are outsourced only to companies who can deliver according to the terms stipulated in agreements and linked to health outcomes and quality of care for local populations.

NHS organisations invest time and resources to train and develop staff to deliver services. We feel that outsourcing to private, external companies can lead to a shortage of future specialised staff in the NHS and should be used only when a service cannot be delivered by existing NHS resources. The proposed new regime and the best value test should take this issue into consideration in procurement processes.

Competition and procurement law in the UK is understood to be linked to EU law through the Public Contracts Regulations 2015. Although there is disagreement as to how much EU law and the Public Contracts Regulations 2015 contributes to the restrictions set by the Health and Social Care Act 2012, the ease with which legislation around procurement and competition can be changed may depend considerably on how the UK will exit the EU, whether there will be a transition period as part of a withdrawal agreement and on the future trade relationship between the UK and the EU.

Paradoxically a 'no deal' situation, which is deemed by most experts to be highly damaging to the NHS and the healthcare sector[xi], could allow changes to elements of this legislation to be passed quicker.

3. **Increasing the flexibility of national NHS payment systems. This includes the following proposals:**
    - **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)**

We support in principle increased flexibility in the NHS pricing regime, as long as tariffs are based on real value of delivering services and appropriate remuneration for emergency workload. Any tariff should reflect the real market price of delivering services (e.g. for a surgical operation it should reflect the hours of work involved and the price of consumables actually needed) and we support rational ways of setting tariffs which we would like to see the NHS adopt. There are now sophisticated models for setting surgical-anaesthetic tariffs that reflect true costs and these should be incorporated into tariff setting[xii] [xiii].

Increased flexibility of the tariff system should encourage change and innovation and a system that fits the money around services as opposed to the current model of fitting services into financial envelopes.

In our submission to the NHS Long Term Plan[xiv] we have made the point that payment systems should incentivise integrated care pathways, not isolated interventions, in order to deliver the best outcomes for patients.

With the evolution of perioperative care, we want to see a cultural shift toward patient-focussed perioperative outcomes, incentivised by an appropriate payment system.
A perioperative care pathway that incorporates comprehensive assessment in advance of any procedure may lead to a clinically appropriate decision that surgery is not the best option for a patient, but providers should not be financially worse off for offering the 'no treatment' option.

A rational tariff system, supported by appropriate changes in legislation, should support the reality that now perioperative care pathways and integrated care systems deliver the best outcomes for patients and local populations. It is no longer appropriate to set tariffs only for individual components of such a clinically integrated system.

4. Integrating care provision. Enable the Secretary of State to set up new NHS trusts to provide integrated care.

We support these proposals and we are reassured by the consultation document's intention for these 'integrated care trusts' to be "only established where local commissioners wish to bring services together under a single contract, where there has been appropriate local engagement and where it is necessary to establish a new organisational vehicle for these purposes."

We recommend however that any decisions made around integrated services must have at their heart the best interest of patients. Clinicians must be fully involved in the development, governance and delivery of the integrated care trusts and there must be proper consultation with patients and patient groups locally to inform decision-making.

Newly created integrated trusts must also work in a coordinated way to ensure that decisions taken by one provider organisation in one area do not negatively impact a neighbouring provider organisation.

5. Managing the NHS's resources better. This includes the following proposals:

- **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 support in principle the proposals for NHS Improvement to be able to set capital spending for foundation trusts as it does for NHS trusts.

At a national level we remain concerned however that capital budgets that were intended for the maintenance of facilities and rollout of new technologies and equipment have been used to fund shortfalls in revenue budgets and reduce provider deficits in 2014/15, 2015/16 and 2016/17.[xv]

An analysis in the Health Foundation's recent report *Failing to Capitalise*[xvi] casts doubt on the ability of the NHS to deliver the transformation of services set out in *The* NHS Long Term Plan, and warns that ongoing maintenance and infrastructure issues could risk the quality and safety of patient care.

We believe that when changes to frameworks around capital spending are planned, there should be a 'quality of care' element embedded within decision-making. For example, we are concerned by the erosion of rest facilities in hospitals. The RCoA has warned that the removal of, for example, on-calls rooms adversely affects fatigue levels (and hence morale and retention of) junior doctors and is a threat to patient safety[xvii].

Thus, while we support changes in legislation that facilitate better use of capital funding for the improvement of NHS infrastructure, the deficit in the DHSC capital budget needs to be addressed urgently. The Spending Review in 2019 could be used to provide dedicated capital funding for improving NHS staff facilities, including provision of adequate rest, catering and study facilities.

6. **Every part of the NHS working together. This includes the following proposals:**
    - **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**

We strongly support these proposals which aim to foster stronger links and collaboration between different parts of the NHS and the health and social care sector. There is potential in closer collaboration to ensure standardisation of governance processes across all providers, better sharing of data for population health management, shared learning and supporting whole workforces across a system as opposed to its component parts.

We welcome the proposal to allow secondary care doctors appointed to CCG governing bodies to be clinicians who work for local providers. This will ensure that there is appropriate clinical expertise on CCG bodies that reflects the provider environment and helps strengthen the commissioner-provider link. Joint committees could include representation from the full range of healthcare professions contributing to the perioperative pathway.

However, in order to enable clinical involvement, clinicians must be released from their Trusts to contribute to this and other crucial roles for the benefit of the wider NHS. It is becoming increasingly difficult for clinicians to get time off from their clinical duties to fulfil non-clinical roles and we call for a formal commitment from NHS England, NHS Improvement and Trusts' management on how they will support and enable clinicians to participate in non-clinical roles.

7. **Shared responsibility for the NHS. Create a new shared duty for all NHS organisations to promote the 'triple aim' of better health for everyone, better care for all patients, and efficient use of NHS resources, both for their local system and for the wider NHS**

We support the introduction of a new 'shared duty' requiring 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.

This ambition aligns with the aims of perioperative medicine, which is a natural evolution in integrated healthcare, using existing skills and expertise to provide an improved level of patient care as set out in the NHS Long Term Plan.

Anaesthetists are the largest single specialty of hospital doctors in the NHS. Two in three hospital patients will receive care from an anaesthetist in a wide variety of settings, most commonly before, during or after surgery – the perioperative period.

The anaesthetic team is therefore uniquely positioned to engage with patients to support healthier changes to their lifestyle before surgery – 'prehabilitation' – and support optimal recovery after a surgical procedure – rehabilitation – reducing the chance of an avoidable readmission.

The period around an operation is a 'teachable moment' where perioperative interventions such as smoking cessation, weight management or psychological support services can lead to sustained lifestyle changes or reduced short-term postoperative pain.

There are examples of perioperative strategies, focussed on improving nutrition and mobility before and after surgery, leading to reductions in postoperative complications of more than 50%. In some cases, severe surgical complications can increase a patients' length of stay in hospital by as much as 271%.[xviii]

High quality perioperative care is good for patients, good for the NHS and good for the economy as well, and we support legislative changes that support its aims.

8. **Planning our services together. This includes the following proposals:**
   - **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 these proposals and we recommend that any future commissioning should take into account current models that are available for costing anaesthetic services[xix].

9. **Joined up national leadership. This includes the following proposals:**
   - **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 *(and create new functions of ALBs)***

As healthcare organisations continue to assemble into integrated care systems it is critical that the services they provide to patients continue to be evaluated by the Care Quality Commission. The House of Commons Health and Social Care Select Committee put forward recommendations in its report from the *Integrated care: organisations, partnerships and systems inquiry*[xx] for changes to the CQC's powers to be made in order to reflect the changing healthcare landscape.

The King's Fund points out that under current legislation the CQC has to be invited to inspect integrated care systems and these are 'reviews' rather than inspections[xxi].

As the ambitions of the Long Term Plan for integration are realised, patient safety must remain a key priority. Current legislation around regulatory frameworks and inspections by the CQC of integrated care systems should be regularly reviewed in the interest of maintaining patient safety and experience throughout the evolution of integrated care.

Beyond what you've outlined above, are there any aspects of this engagement document you feel have an impact on equality considerations?
No response to this question.

Other comments?
No response to this question.

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[i] NHS Digital. *NHS Hospital & Community Health Service (HCHS) monthly workforce statistics - Provisional Statistics*. July 2017.
[ii] Stats Wales. *Medical and dental staff by specialty and year.* March 2017.
[iii] Information Services Division Scotland. *HSHS Medical and Dental Staff by Specialty*. December 2016.
[iv] Audit Commission. *Anaesthesia under examination: The efficiency and effectiveness of anaesthesia and pain relief services in England and Wales*, National report, 1998.
[v] EMK Walker, M Bell, TM Cook, MPW Grocott, and SR Moonesinghe for the SNAP-1 investigators. Patient reported outcome of adult perioperative anaesthesia in the United Kingdom: a cross-sectional observational study. British Journal of Anaesthesia 2016
[vi] NHS England. *Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21*. December 2015
[vii] Alderwick, H et al. *Sustainability and transformation plans in the NHS: How are they being developed in practice?* The King's Fund. November 2016
[viii] Royal College of Anaesthetists. *Perioperative Medicine – the pathway to better surgical care*.
[ix] Royal College of Anaesthetists. *Perioperative medicine: The pathway to better surgical care*. 2014
[x] King's Fumd. *Amending the 2012 Act – can it be done?.* 25 October 2018
[xi] Fay N et al. *How will Brexit affect health services in the UK? An updated evaluation*. The Lancet. Volume 393, issue 10174, p949-958, March 02, 2019
[xii] Abbott T et al. Factors affecting profitability of surgical procedures under 'Payment by Results'. *Anaesthesia* 2011; 66: 283-292.
[xiii] *Practical Operating Theatre Management*. Cambridge University Press. 2018. ISBN 978-1-316-64683-0.
[xiv] Royal College of Anaesthetists. *Safe. Sustainable. Effective: developing a long-term plan for the NHS*. 01 October 2018
[xv] House of Commons Public Accounts Committee. Financial sustainability of the NHS. Risks to future performance. February 2017
[xvi] The Health Foundation. *Failing to capitalise – Capital spending in the NHS*. March 2019
[xvii] Royal College of Anaesthetists. *A Report on the Welfare, Morale and Wellbeing of Anaesthetists in Training: The need to listen*. 2017.
[xviii] Based on the variation in mean postoperative length of stay for Urology patients in the PQIP Annual report (2017-18) comparing those with complication up to Clavien-Dindo grade II and grade III.
[xix] *Practical Operating Theatre Management*. Cambridge University Press. 2018. ISBN 978-1-316-64683-0.
[xx] Health and Social Care Committee. *Report of the Integrated care: organisations, partnerships and systems inquiry*. 11 June 2018
[xxi] King's Fund. *Amending the 2012 Act – can it be done?.* 25 October 2018