Health Foundation submission to the Health and Social Care Select Committee inquiry into legislative proposals in response to the NHS Long Term Plan

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About the Health Foundation

The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK. Our aim is a healthier population, supported by high quality health care that can be equitably accessed. We learn what works to make people's lives healthier and improve the health care system. From giving grants to those working at the front line to carrying out research and policy analysis, we shine a light on how to make successful change happen.

Summary of key points

- The Health Foundation welcomed the NHS Long Term Plan (the Plan) as an ambitious vision to improve NHS care. The Plan emphasises the need for collaboration within the NHS to improve care and manage resources. NHS England and NHS Improvement's proposals for legislative changes in Implementing the NHS long term plan: proposals for possible changes to legislation aim to align the rules for the NHS in England with the ambitions for improving care described in the plan.

- The proposals could make it simpler for mergers involving foundation trusts to take place - including at the direction of NHS Improvement. What is not clear is whether more mergers in the NHS would necessarily be beneficial to patients and the system. Evidence on the impact of NHS hospital mergers on costs and quality is mixed. The proposals are not clear on how these benefits would be robustly assessed in future.

- The proposals related to competitive tendering could provide greater clarity for NHS commissioners seeking to plan and coordinate local services. A new 'best value' test is proposed to guide commissioners in deciding whether to award contracts directly to NHS providers or to competitively tender. It is not yet clear how such a test would work. The risk is that one set of complex and confusing rules is replaced with another.

- The proposed changes on competitive tendering also need to be considered in relation to wider competition law and in the context of European Union (EU) rules. These proposals may not be possible without making wider policy changes such as bringing foundation trusts back under direct government control.

- A number of proposals aim to support the development of more integrated care. This is welcome, but integrating NHS organisations and creating new contracts is not the same as integrating services. Other approaches related to leadership, culture and management are likely to be just as, if not more, important for supporting the development of new, integrated models of care than technical changes to contracts and organisations within the NHS.

- The proposals to support greater collective decision-making between local NHS organisations would formally diminish the strength of the purchaser-provider split, which has existed since 1991. Yet these changes may make little practical difference, and risk creating another workaround to the existing fragmented and complex organisational arrangements at a local level. How sustainability and transformation partnerships (STPs) and integrated care systems (ICSs) will be held accountable remain unclear.

- There is a strong case for aligning the work of NHS national bodies – though the rationale for new powers for the Secretary of State to transfer and delegate functions between national bodies without primary legislation is unclear.

- Taken together, the proposals add up to several shifts in the direction of the NHS, including from competition to collaboration, increased centralisation of power from local to national bodies, and consolidation of NHS organisational arrangements. They also raise important questions related to accountability, patient choice and the mechanisms for driving improvements in performance across NHS services.

- National NHS leaders should more clearly articulate the rationale for these changes, and the logic for how services will improve as a result. Aside from the detail of each proposal, NHS leaders must ask themselves whether changes to NHS legislation – however logical from a technical perspective – will bring additional costs, upheaval, and unintended consequences, such as directing resources away from front-line care.

Introduction

In January 2019, NHS national bodies published the Plan – a ten-year strategy for the NHS in England. The Plan included suggestions for changes to NHS legislation to support its implementation. NHS England and NHS Improvement have since published a consultation document, *Implementing the NHS long term plan: proposals for possible changes to legislation*, setting out these proposed changes in more detail.

The Health Foundation welcomed the Plan as an ambitious vision to improve NHS care. However, making this vision a reality will be extremely tough, given growing pressures on services, widespread staff shortages, and continued cuts to other parts of the health and

care system. We outlined in our joint report *The Health care workforce in England*, the single biggest challenge is the NHS's chronic workforce gap – currently standing at 100,000, but potentially growing to 250,000 or more by 2030.[1] The ability to deliver the Plan also depends on wider political choices outside the control of the NHS – particularly on Brexit, social care, and funding for capital, public health, and wider public services.[2]

Given this context, and the damaging and distracting experience of the Health and Social Care Act 2012,[3] any changes to NHS legislation need to be carefully scrutinised, to ensure they do not consume time and resources that could be directed towards improving front-line care. The proposals, if turned into law, could have a significant impact on the way the NHS works – some intentional, some unforeseen.

In this submission, we analyse the proposals for changes to NHS legislation made by NHS England and NHS Improvement. To do this, we:

- set the proposals in the context of recent NHS policy developments
- summarise the proposals and highlight the relevant available evidence
- offer our overall assessment based on the combination of proposals made.

We focus largely on the substance of the proposals rather than their potential legal impact.

We highlight a set of questions to the Select Committee as areas to explore in their inquiry.

Policy context

The Plan builds on the *NHS Five Year Forward View* [4] which set out a vision for how NHS services need to change in response to the changing needs of the population. These changes included placing a greater focus on prevention and developing more integrated models of care. A series of more detailed plans for specific services soon followed – for general practice, mental health, cancer, and maternity – as well as the introduction of sustainability and transformation plans (STPs) in 2015.[5]

STPs (now renamed as sustainability and transformation partnerships) are geographically-based partnerships of NHS commissioners, providers, and local government in 42 (previously 44) parts of England. STPs were initially tasked with producing plans for improving local services – a process that produced mixed results.[6,7] Despite having no statutory authority, STPs have become a core unit of NHS planning. STPs have named leaders, CCGs are merging to fit their boundaries,[8] and national performance frameworks have been established to assess them.[9] STPs are now expected to evolve into ICSs – more formal versions of STPs that will have a central role in the delivery of the Plan.

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.

The result is a growing gap between the legal framework for the NHS and the reality of how the system is managed. This has created tensions for NHS organisations stuck in the middle. For example, NHS commissioners must navigate rules on competition and procurement as they seek to promote integration of care. NHS England's wider approach to developing new care models has also been tested twice in court – first in relation to testing the legality of departing from the national tariff,[10] and second through a legal challenge to the perceived delegation of commissioning functions via the draft Integrated Care Providers (ICP) contract.[11] Neither of these challenges succeeded, but the Plan makes the case that the law as currently constructed will constrain progress towards developing more integrated models of care.

It is in this context that NHS England and NHS Improvement have made proposals for changes to the legal framework for the NHS. Leaders of NHS national bodies are proposing legislative changes to government, in an attempt to bring the rules governing the NHS closer to the direction the system is already heading, in the hope it can get there faster.

Analysis of the proposals

Mergers involving foundation trusts

Prior to the 2012 Act, proposed mergers involving an NHS foundation trust were reviewed by the NHS Cooperation and Competition Panel to establish whether potential benefits of consolidation outweighed any potential negative impacts of reduced competition and choice.

The first merger considered under the revised process established by the 2012 Act was the proposed merger of Poole Hospital NHS Foundation Trust and Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. The merger was prohibited by the Competition Commission – now part of the Competition and Markets Authority (CMA) – in 2013, on the grounds of insufficient evidence of patient benefit. Our analysis concluded the trusts' case had suffered at a time when the process and criteria for applying for mergers were not clear. The application for merger coincided with the bumpy passage through parliament of the Health and Social Care Bill and the comprehensive reorganisation in the NHS following the Health and Social Care Act 2012.[12] Following the CMA's decision on Bournemouth and Poole (which was controversial), NHS Improvement (as Monitor) and the CMA published further guidance on demonstrating patient benefit, and sought to improve sector knowledge of the merger control regime.[13] All proposals for mergers and acquisitions involving foundation trusts have since been permitted to proceed.

The proposed changes would remove the role of the CMA in reviewing mergers involving NHS foundation trusts (proposal 1) and give NHS Improvement a new power to direct foundation trusts to prepare for, and enter into, mergers and acquisitions (proposal 5). An underlying assumption behind these proposals is that mergers could bring benefits to the NHS and its patients, and that these benefits would be greater than any negative effects of reduced competition and choice.

There is still limited evidence about the benefits and costs of competition for clinical services between trusts. Various studies have tried to assess the impact of NHS competition on quality and efficiency of care.[14,15,16,17,18,19,20] But after almost 30 years of the internal market, evidence on the potential benefits of competition between NHS trusts is mixed and, overall, weak. Other factors shaping the context of care delivery in today's NHS, such as regulation, rising demand, growing waiting lists, limited funding growth, and widespread staff shortages,

are likely to have a far greater impact on quality than competition. As a result, there may be better prospects for NHS trusts to improve services through collaboration.

At the same time, evidence on the impact of NHS mergers on quality and costs of care is also mixed. There is little evidence that hospital mergers in the NHS produce their intended financial or quality benefits.[21,22,23]Mergers can be costly, time consuming, and cause organisational distraction, but they can also help drive up standards.[24] There are also various other options for NHS providers to collaborate[25] – for example, through twinning or partnering for improvement, clinical networks, and hospital groups – that may be more effective and less costly than trust mergers.[26]

The consultation document states that NHS Improvement should only use its power to direct mergers (proposal 5) in specific circumstances where there are clear patient benefits. Previous experience suggests that the articulation of benefits from potential mergers is often weak.[27] It is not clear how NHS Improvement would assess potential impacts of NHS mergers or how patient benefits, including choice of provider, would be robustly scrutinised in the absence of the CMA.

The Committee may therefore wish to explore:

- The circumstances in which NHS England and NHS Improvement will allow trust mergers and acquisitions
- What arrangements, if any, will be in place to ensure patients benefit from such transactions?
- What process will there be to assess other options for organisational collaboration, such as clinical networks or twinning of Trusts, compared with structural mergers?
- What lessons have been learned from previous trust mergers to ensure that intended quality and economic benefits can be realised more readily?
- How can the evidence base be strengthened, given the mixed and weak evidence after 30 years of the internal market?

Redefining the internal market

The 2012 Act strengthened the use of market mechanisms within the NHS. For example, Monitor (now part of NHS Improvement) was transformed into the economic regulator for the health service, with duties and powers to address anti-competitive behaviour and ensure a level playing field for all prospective providers of NHS-funded care. A new set of legal mechanisms were also created for setting and applying the national tariff, including a role for the CMA in reviewing contested decisions around the provider license and national tariff provisions.

The changes proposed by NHS England and NHS Improvement aim to:

- Replace the current requirements around competitive tendering with a lighter touch regime (proposal 2)
- Remove NHS Improvement's role as the NHS competition regulator (proposal 1)
- Increase the flexibility of national NHS payment systems (proposal 3)
- Allow new NHS trusts to be created to hold ICP contracts (proposal 4).

Procurement requirements

A key assumption in the 2012 Act was that the quality and financial benefits of competitive tendering would outweigh the associated costs of procurement processes. The consultation

document suggests these benefits have not been achieved in practice. It also makes the more fundamental argument that commissioners in a publicly funded health service should be able to plan services and identify NHS providers to deliver them, without necessarily putting these services out to tender – particularly given the system's focus on developing more integrated models of care. These arguments are likely to find support within the NHS.

Qualitative evidence suggests that current procurement requirements are poorly understood by both NHS commissioners and providers, and that a mix of competitive and collaborative approaches are already used to commission services.[28] As NHS organisations increasingly work together to coordinate services through STPs and ICSs, commissioners risk falling foul of existing procurement rules and facing legal challenges from private providers.

Evidence on the costs and benefits of the current procurement regime is limited. In community services, for example – where spending on services delivered by non-NHS providers has increased faster than any other area of spend in recent years – there is little public information about who provides services, or the size and scope of contracts.[29] More broadly, limited NHS data exist on costs, activity and quality in community services.[30] Yet these services are disproportionately subject to competitive tendering.[31] This creates obvious risks, where contracts may constrain costs at the expense of quality.

There is potential to provide greater clarity for NHS commissioners seeking to plan and coordinate local services, as well as reducing some barriers to integrating care. To realise this, the consultation document proposes a new 'best value' test to guide NHS commissioners in deciding whether to award contracts directly to NHS providers or to competitively tender. But there is no detail on how this would work in practice. The risk is that one set of complex and confusing rules is replaced with another. Experience in other parts of the public sector is not promising. The UK government spends around £250bn a year on outsourcing and contracting, with little evidence that it follows its own procedures on value for money.[32]

The proposed changes also need to be considered in relation to competition law more broadly and current EU rules – or, indeed, any future arrangements with the EU. The procurement of health services in the NHS is carried out under regulations made under section 75 of the 2012 Act and the Public Contract Regulations 2015, which implement EU rules on public procurement. As the nature of the UK's future relationship with the EU is currently unclear, it remains possible that these rules will continue to apply to the UK in some form. The consultation document is not clear whether commissioning decisions are intended to remain subject to domestic competition law, in the absence of an equivalent regime for the NHS.

If the intention is to remove these decisions from the scope of EU and domestic competition requirements entirely, changes may need to go further than those proposed in the consultation. Previous analysis of comparable Labour Party proposals to exempt the NHS from procurement rules concluded that this would require policy changes such as bringing foundation trusts back under direct government control.[33] These changes have not been suggested by NHS England and NHS Improvement, although several other proposals would limit foundation trust autonomy (such as proposals for national NHS bodies to set NHS trusts' capital expenditure limits).

The Committee may therefore wish to explore:

- To what extent is the NHS still subject to the Competition and Enterprise Act, and who decides this?
- Would NHS England and NHS Improvement advocate bringing foundation trusts under direct state control, if this was found to be needed to remove trusts from the scope of competition law?
- How do NHS England and NHS Improvement expect the new 'best value' test for procurement processes to operate?
- How would the NHS prevent anti-competitive behaviour in procurement decisions that disadvantages patients if the current roles of NHS Improvement and the CMA are removed?
- What lessons have been learned from the current procurement requirements to ensure quality and economic benefits can be realised more readily?

National tariff

The 2012 Act determines how the national tariff (that sets national prices for units of care across all acute providers) is set and applied, to regulate how these functions would be exercised by national bodies without the direct involvement of Ministers. NHS England and NHS Improvement are increasingly seeking to develop alternative payment models to the national tariff, such as whole population budgets, to support providers to collaborate to improve care and manage resources. While it is possible to do this within the existing legal framework, these flexibilities are limited. The proposed changes would allow NHS England and NHS Improvement greater flexibility over how the tariff is set nationally and applied locally, including removing the role of the CMA in reviewing contested tariff provisions.

Clarifying the law to provide greater flexibility to experiment with alternative payment models makes sense. The current combination of payment systems in the NHS do not always provide the right incentives to improve care.[34] For example, the combination of case-based activity payments for most acute services and block payments for services outside hospitals can undermine efforts to provide more care in the community.

But while payment systems can have an impact on health care quality and efficiency, they are a blunt and ultimately limited tool for improvement.[35,36] There is no single payment approach that will transform NHS care on its own; an effective payment system is likely to combine multiple methods, and work alongside other approaches to improvement. This means that NHS leaders must be realistic about what new payment models can achieve. Ongoing monitoring and evaluation will also be needed to understand the impact of any new payment models introduced, before these approaches are spread across the NHS.

The Committee may therefore wish to explore:

- How important a role do NHS England and NHS Improvement expect the payment systems to play in delivering the ambitions in the plan?
- What assessment has been made of the risks that local pricing flexibilities could lead to price-based competition between providers?
- How will any learning from experiments with new payment models and the use of the proposed local flexibilities be captured and shared?
- What, if any, independent oversight will there be of how the proposed flexibilities are used if the CMA's role is removed?

Integrated care providers and contracts

Related to NHS England and NHS Improvement's proposals to introduce greater flexibility over NHS payment systems, the consultation document also proposes to amend legislation to allow the creation of new NHS trusts 'to integrate care across a given area'. These new trusts would hold 'integrated care provider contracts', which could include all NHS services for a defined population, as well as adult social care and public health services. The assumption here is that bringing together budgets and services into a single organisation will support the development of more integrated care – for example, to provide greater flexibility to organise staff and resources between different parts of the health system.

The ambition to develop more integrated models of health and social care is a good one. Better coordination between services can improve patient satisfaction and perceived quality of care, though evidence on health outcomes, service use, and costs is less clear.[37,38]

Integrating contracts and organisations, however, is not the same as integrating services. Our analysis of the NHS' new care models programme found that changes to organisational and governance structures were not initial catalysts for change.[39] NHS England's own contracting support documents rightly state a new care model 'cannot simply be willed into being through a transactional contracting process'.[40]

A focus on new contractual arrangements must not neglect the groundwork required to make meaningful changes to the way care is delivered. There is also a risk that a focus on restructuring providers may disrupt some of the productive relationships that already exist within local health and care systems. Other approaches to supporting the development of new service models – such as use of quality improvement methods, dedicated resources for care redesign, and other approaches related to leadership, culture, and management – are likely to be just as, if not more, important than technical changes to contracting models and organisational arrangements in the NHS.[41]

The Committee may therefore wish to explore:

- How many new NHS trusts do NHS England and NHS Improvement expect to be created to hold ICP contracts?
- What other options might be available for NHS organisations to collaborate to deliver integrated services, without requiring new organisations?
- What arrangements, if any, will be established to provide assurance that the decision to create a new trust is the most appropriate option?
- Is it anticipated that the new trusts will hold only single or multiple contracts, and how will they be held accountable locally and nationally?
- What are the implications of new integrated providers on patient choice? How would any unintended consequences – such lack of provider responsiveness to patient need – be monitored and managed?

Supporting local health systems to collaborate

The proposals published by NHS England and NHS Improvement include a number of changes that can be grouped together under the common objective of supporting better collaboration across local health systems.

The changes aim to:

- Provide a mechanism for joint decision making on local priorities by CCGs, NHS trusts and foundation trusts (Proposal 6)
- Allow clinicians who work for local providers to be appointed to CCG governing bodies (Proposal 6)
- Clarify that the law allows CCGs and providers are able to make joint appointments across organisations (Proposal 6)
- Establish a new shared duty for CCGs, NHS trusts and foundation trusts to promote the 'triple aim' of better population health, better patient care and better use of resources (Proposal 7)
- Allow groups of CCGs to collaborate to arrange service for combined populations and carry out delegated functions (Proposal 8)
- Enable NHS England to enter into joint commissioning arrangements with CCGs, including the ability to pool budgets (Proposal 8).

Since the establishment of the internal market in 1991, there has been a division between purchasers (commissioners) and providers of NHS services. The 2012 Act sought to further strengthen the role of competition in the NHS. Yet – as we have described – STPs and ICSs have since been introduced to bring commissioners and providers closer together to improve care and manage local resources. The Plan continues this emphasis on local collaboration, and expects STPs and ICSs to lead service improvements in their area.

The challenge is that STPs and ICSs are not statutory bodies and have no formal powers or authority to lead local changes. This has made it difficult for NHS organisations and their partners to make collective decisions through STPs.[42] It also creates an accountability gap at STP level, as individual organisations—for example, NHS trusts and foundation trusts—are still legally responsible for their own budgets and performance. Who, then, is legally responsible for improving services at an STP/ICS level? Given these issues, there is a clear case for changing the legal framework to support collective decision-making at a local level.

The proposals to do this in the consultation document are simultaneously significant and underwhelming. On the one hand, the proposals add up to a formal diminishing – albeit not a destruction – of the purchaser-provider split. New joint committees would be established spanning NHS commissioners and providers, with some way for decisions to be delegated to them. While not clear how this would work in practice, it raises important questions of policymakers: are we accepting that the 30-year experiment of the internal market has failed? If so, what have we learnt from the evidence and experience along the way?[43,44,45]

On the other hand, the proposals may change very little. NHS organisations will be offered new ways to collaborate through joint committees, joint commissioning arrangements, and joint appointments. New ways to commission services jointly could help CCGs overcome some of the fragmentation in the existing commissioning system.[46] But no new types of statutory body – for instance, ICSs – would be created under these proposals. And NHS commissioners and providers would still be faced with the potentially conflicting requirements to plan services together but commission them separately. In this sense, the proposals risk replacing one set of complex workarounds with another. The consultation document also fails to outline how national NHS bodies will shift their approach to regulation and performance management under these arrangements.

The Committee may therefore wish to explore:

- To what extent will the proposed changes make a practical difference to supporting STPs and ICSs in delivering the 'triple aim'?
- Who will be accountable for improving local services under the new arrangements?
- How will conflicts of interests be managed between ICSs, CCGs, and—if they are developed—ICPs?
- Will the proposals provide sufficient room for STPs and ICSs to develop their system leadership role in the way described in the NHS Long Term Plan?
- Is it sustainable to maintain STPs and ICSs as purely administrative bodies, despite their increasing importance as the intermediate tier of the NHS?
- How can patients exercise choice if there is effectively no choice of commissioner and staff from the local ICP are on the boards of the local CCG?

Joined-up national leadership

The 2012 Act distributed national functions for the NHS across a larger number of bodies operating at arm's length from the Secretary of State. This fragmented national responsibility for the NHS.[47] The bodies now known as NHS England and NHS Improvement were established to act as the national bodies for commissioning and provision respectively.

Work has already begun on developing a joint operating model for NHS England and NHS Improvement but, as highlighted in the consultation document, there is a limit to how closely the two organisations can work together in the discharge of their functions. The two bodies are now proposing to use legislative change to enable closer integration at national level, to reflect the changes expected at a local level through STPs and ICSs.

There is a strong case for resolving some of the tensions inherent in closer working between three quite different national bodies. NHS England is the non-departmental public body (NDPB) responsible for a budget that accounts for three quarters of spending on public bodies.[48] Monitor is the NDPB that regulates NHS providers, with a distinct set of duties, functions and powers. Whereas the NHS Trust Development Authority is a special health authority and may only exercise powers delegated by Ministers. Enabling these bodies to exercise their respective functions in concert is complex, but the two options proposed to do this are notably lacking in detail.

The consultation document also proposes a new power for the Secretary of State to transfer and delegate functions between national bodies without the need for new primary legislation. What has motivated this proposal – and how it could be used – is not entirely clear. There is a long history of governments embarking on time consuming, disruptive and expensive programmes to restructure public bodies to improve the discharge of their functions, without achieving the intended benefits.

The Committee may therefore wish to explore:

- Is there a more detailed plan for how legislation would be amended if the option of providing greater flexibility to work jointly were preferred?
- Do NHS England and NHS Improvement have a clear vision for how a merged organisation would operate, if this option is preferred?
- How would the newly merged organisation avoid the well-known pitfalls associated with past instances of merging large and complex public bodies?
- How might the Secretary of State look to exercise the proposed new power to transfer or delegate functions between the national bodies?

Conclusions

There is much to welcome in the Plan. But the proposals for legislative change made by NHS England and NHS Improvement raise complex questions about how the system will be managed and governed in the future. Aside from the detail of each proposal, NHS leaders and policymakers must ask themselves the broader question of whether changes to NHS legislation – however logical from a technical perspective – will bring additional costs, upheaval, and unintended consequences on the system. As with the Plan, the biggest challenge with these proposals will lie in implementation.

Taken together, the proposals represent several important shifts in the direction of the NHS.

They include:

- Increasing centralisation of power from local to national NHS national bodies – for example, through proposals for NHS Improvement to direct trust mergers
- Increasing centralisation of power at a national level – for example, through the proposed merger between NHS England and NHS Improvement
- A continued move from competition to collaboration as the chosen lever for service improvement – for example, through revised rules on competitive tendering
- Consolidation, though not necessarily simplification, of NHS organisational arrangements at a local – for example, through ICPs and trust mergers
- The continued diminishing – though not destruction – of the purchaser-provider split and competition as the broad policy to speed up improvements in the NHS
- A potential reduction in patient choice pursued in the NHS over the last 30 years.

If this is the direction of travel, national NHS leaders should more clearly articulate the logic for how the system will improve as a result. If the internal market is a thing of the past, what policy levers will be used to drive continued improvements in NHS care? Traditional approaches to NHS reform include top-down command and control (for example, directives from Whitehall), financial incentives (for example competition and choice), provider assessment and regulation (for example, through the Care Quality Commission), and local accountability (for example, through joint working with local government). The Health Foundation has emphasised the importance of quality improvement approaches – of giving NHS organisations and teams the skills and resources needed to improve care. Part of the answer is likely to lie in closer analysis of evidence on the impact of reform approaches to date, as well as a commitment to learning and testing where the evidence is lacking.

Where next?

In terms of next steps, the consultation document is largely silent on what happens now to progress the proposals into law, beyond the consultation. NHS England and NHS improvement should set out a clearer narrative of the aims and assumptions guiding the development of the proposed legislative changes, and their intended impact on the NHS. For example, has choice and competition been deprioritised across the full range of NHS care, or only where integration and collaboration are assumed to be more effective? Making these assumptions clear is a necessary step in ensuring the impact of these changes can be meaningfully evaluated, which has often been no more than an afterthought in previous structural changes in the NHS. On a practical level, it would be helpful for the committee to clarify who is responsible for turning the proposals into detailed policy changes and draft

legislation. It will also be important to clarify whether that legislation will receive government support and parliamentary time, in whatever form it ultimately takes.

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