

Proposals for possible changes to legislation

The NHS long term plan sets out NHS England's and NHS Improvement's (NHSE/I) view that the current policy direction towards collaboration and integration within local systems can "generally" be achieved within the current statutory framework, but that "legislative change would support more rapid progress". The plan included an overview of barriers to collaborative working which NHSE/I would like to address via legislative change. They have now published an engagement document, *Implementing the NHS long term plan: proposals for possible changes to legislation*, setting out their top level proposals for change. These were described in terms of the plan depending "mainly on collective endeavour", with local and national NHS bodies needing to work together to redesign care around patients.

There is an eight week period in which to submit responses to the proposals. This briefing document summarises NHSE/I's proposals and gives NHS Providers' initial analysis, as well as our press statement. We have also set out a number of questions for members, and would be grateful for your views and experiences – **please send any comments to Ferelith Gaze (ferelith.gaze@nhsproviders.org) by 22 March** to ensure they can be properly reflected in our response. You may also want to submit your own response – we suspect that different members may have different views on some of the proposals, depending on their particular circumstances.

NHS Providers' overall view

The passage of these proposals will unfold against the backdrop of a number of difficult realities facing NHS legislation. There is the practical issue of Brexit dominating the parliamentary timetable for some time to come. There is the political sensitivity for the Conservative government in bringing forward health legislation after the Lansley reforms. There is also the tension between wishing to avoid further upheaval for the frontline, even while current structures may be presenting unnecessary barriers.

The long term plan, and the Secretary of State, have been keen to argue that any proposals should come from the NHS itself, rather than be politically driven, and that there should be a consensus in taking them forward. For the same reason, the proposals make piecemeal rather than wholesale changes to NHS legislation.

However, NHS legislation on issues of integration (and therefore competition) and on the scale proposed here need detailed, robust and transparent scrutiny. In particular, we would note that the proposals introduce the potential for both greater integration, but also greater intervention by the NHS arm's length bodies. We also need to consider whether alternative, non-legislative approaches would, in some cases, be more reasonable and proportionate. Where legislation is the appropriate response, given the complexity and sensitivity of NHS legislation, further consideration is needed as to how to avoid unintended

consequences. This will be particularly important since any individual changes on particular issues need to work within and maintain the clarity and consistency of the existing wider legal framework which will remain unchanged.

NHS Providers would therefore welcome member views on the overall direction of travel of these proposals.

Summary and initial analysis of proposals

Below we summarise each of the proposals and give our initial analysis. We will develop this analysis in the coming weeks as we consider the implications of changes. We are seeking member feedback on the proposals, and your experiences of current legislation and regulations to develop the evidence base for our formal response to NHSE/I. We will also continue to seek to influence proposals, and involve trusts, over the coming weeks and months through a range of avenues. We are pleased that the document makes specific reference to the importance of NHS Providers' involvement in the drafting process (para 41).

Collaboration and competition

Summary of proposals

NHSE/I are concerned that current competition requirements act as a drag on efforts to improve collaboration between NHS bodies and provide integrated care. The Competition and Markets Authority (CMA) has powers to investigate and intervene in proposed NHS mergers. As the NHS is a publicly funded service, democratically accountable to the Secretary of State and to Parliament, NHSE/I consider that the NHS should be able to make its own decisions in relation to mergers, taking into account the potential benefits for patients.

PROPOSAL 1: removing the CMA's function to review foundation trust mergers

NHS Improvement has concurrent powers with the CMA to apply UK and EU competition law to the provision of healthcare services in England. NHSE/I do not think it necessary for these powers to be held in parallel, and their removal would allow greater focus on oversight of and support for improvement. NHS Improvement would still be able (through licence conditions) to prevent anti-competitive behaviour in certain circumstances where it is against patients' interests.

PROPOSAL 2: removing NHS Improvement's competition powers and duties to prevent anti-competitive behaviour

Under the 2012 Act, where there are sufficient objections to proposed licence conditions or the national tariff payment system, NHS Improvement must either refer the relevant proposals to the CMA or consult on a revised set of proposals. NHSE/I consider that NHS Improvement (with NHS England in the case of the tariff) should be able to reach final decisions on these matters without referral to the CMA, provided it has consulted on the proposals and given any concerns raised proper consideration.

PROPOSAL 3: removing the need for NHS Improvement to refer contested licence conditions or national tariff provisions to the CMA

NHS Providers initial analysis

NHS Providers' view is that while competition can, in some circumstances, be one driver of quality and service improvement in the NHS, it must be applied carefully and sensibly to the ultimate benefit of patients. In other circumstances, over rigid application of competition principles can operate against the interest of patients. For example, a number of providers have been seeking to undertake mergers or acquisitions to address workforce challenges, enable better patterns of service delivery and drive efficiencies. However, the CMA's involvement in the merger approval process has, in the view of many providers, added unnecessary duplication, cost and complexity into the transaction process. We therefore think it likely that most providers will find it helpful to remove the CMA's duty to review provider mergers, as an overly stringent application of competition requirements to the NHS .

However, this proposal should be read in conjunction with proposal 10 (where NHS Improvement seeks the power to direct foundation trust mergers and acquisitions – see later in this document for our analysis). An unintended consequence could be that weakening the role of competition in the NHS also weakens provider board autonomy in the longer term, because the process of deciding service/institutional configurations is centrally directed rather than negotiated and there is no recourse to an independent third party

With regards to the proposal to remove the CMA's potential involvement in licence and tariff objections, this removes a final recourse for providers, albeit one mediated by NHS Improvement. The question to consider here is whether the presence of this backstop has the effect of encouraging robust and reasonable working practices by NHSE/I. It is worth remembering the scale of disagreement between the provider sector and NHSE/I on the framing of the tariff a few years ago when providers triggered the formal tariff objection mechanism. The Government has now amended the terms of that mechanism to make it much more difficult for providers to trigger. We assume members might want to try to secure a "quid pro quo" for the loss of the right of CMA referral, in the form of clear guarantees of what NHSE/I means when it says that it will seriously consider any objections.

Questions for members on proposals 1 to 3

- What elements of the presence of the CMA in the mergers process have been a) beneficial and b) disadvantageous?
- How concerned are you by the proposal to remove the requirements on NHS Improvement to refer to the CMA (a) contested licence conditions and (b) contested national tariff provisions?
- Please could you let us know about any occasions that you have contested, or considered contesting, your licence conditions.
- Do you have any further comments or concerns about these proposals?
- Would you agree with the idea of securing a "quid pro quo" for loss of the right of CMA referral?

Procurement rules

Summary of proposals

Procurement of healthcare services in the NHS is carried out under two sets of regulations: the Procurement, Patient Choice and Competition Regulations (PPCC regulations; made under powers in the 2012 Act), and the Public Contracts Regulations 2015 (implementing EU rules on public procurement).

NHSE/I consider that NHS commissioners should be able to arrange for NHS providers to provide services without necessarily seeking expressions of interest from the wider market. Under the current system, protracted procurement processes incur potentially wasteful legal and administrative costs, and it can be difficult for NHS organisations to collaborate and use their collective resources in the most effective way.

NHSE/I propose that, rather than a necessary procurement process, it would, instead, be for commissioners to use their discretion. The key test in awarding a contract would be whether NHS commissioners were: obtaining “best value” from their resources, in terms of the likely impact on quality of care and health outcomes; whether they were acting in the best interests of patients; and whether they were actively considering relevant issues in making any decisions.

PROPOSAL 4: regulations made under section 75 of the Health and Social Care Act 2012 should be revoked and the powers in primary legislation under which they are made should be repealed and replaced by a best value test

PROPOSAL 5: removing NHS commissioners and NHS providers from the scope of Public Contracts Regulations, and instead making NHS commissioners subject to a best value test, supported by statutory guidance

The way in which the Public Contracts Regulations 2015 can be changed will depend in part on how the UK exits the EU. It will also depend on other legislative proposals which affect the nature of arrangements between NHS commissioners and NHS providers.

In rescinding the PPCC regulations, requirements in relation to patient choice are intended to continue under the standing rules given to commissioners and licence conditions for providers. The power to set standing rules in primary legislation would also be explicitly amended to require inclusion of patient choice rights.

NHS Providers initial analysis

Careful analysis of these regulations is required. It would seem that greater commissioner discretion in procurement processes would be helpful in reducing the burden on trusts, particularly for community and mental health trusts whose services are more regularly subject to tendering. Yet further clarification is required in a number of areas. For example, there is considerable uncertainty about the nature of the amendments to the Public Procurement Regulations, and more widely, the extent to which competition rules will still apply to day-to-day procurement. The definition of and guidance around the “best value test”

will also need further clarification and consideration. Meanwhile, we should be mindful of the role of patient choice and how this would be enacted in absence of the regulations.

Questions for members on proposals 4 and 5

- Rescinding these regulations seems likely to reduce the burden on trusts for retendering, but please let us know if you are aware that there are any elements of these regulations that are beneficial and would otherwise be lost.
- Do you have any further comments or concerns about these proposals? Are you, for example, happy with a return / move to greater commissioner discretion on whether to tender or not?

National NHS payment systems

Summary of proposals

Changes to the national tariff have been made for 2019/20 with the stated objectives of supporting providers and commissioners to work more collaboratively and develop a more aligned system of payments and incentives. The national tariff also already provides for a degree of flexibility, with providers and commissioners able to agree local payment approaches. However, NHSE/I consider that legislative changes could help further this approach.

PROPOSAL 6: on the tariff: (a) national prices can be set as a formula rather than a fixed value; (b) a power for national prices to be applied only in specified circumstances; and (c) allow adjustments to provisions within the tariff to be made (subject to consultation) within a tariff period

Currently, providers can apply to NHS Improvement to make changes to tariff prices if agreement with local commissioners on modifications cannot be reached. NHSE/I view this as out of keeping with moves towards integrated care systems (ICSs) where commissioners and providers take shared responsibility for managing their collective financial resources.

PROPOSAL 7: once ICSs are fully developed, the power to apply to NHS Improvement to make local modifications to tariff prices should be removed

It is not currently possible to set national tariff prices for section 7a public health services commissioned by NHS England or CCGs on behalf of the Secretary of State. This has created difficulties where these services are part of a patient pathway for a particular service, for example, screening newborn babies' hearing as part of their mothers' maternity care.

PROPOSAL 8: national tariff can include prices for section 7a public health services

NHS Providers initial analysis

We will clarify the terms of consultation in adjusting treatments in-year in the tariff. We will also consider further how the payment system would work in practice if prices are set as a formula rather than a fixed value and with national prices for certain circumstances.

We would also question whether it is an appropriate point to remove NHS Improvement's role in resolving disputes over local modifications to prices, even when ICSs are fully developed, as we can still foresee potential for provider / commissioner disagreement as long as there are separate, distinct, statutory entities. We would welcome member views on this. We agree with the ambition that modifications should be agreed locally. However, an emphasis on collaboration over competition and a drive towards integrated care systems are not sufficient drivers to ensure that disputes will not arise in the future. We are also aware that some trusts (for example University Hospitals Morecambe Bay) have used the local modification process to identify where a trust has a structural deficit that commissioners ought to be taking account of in its contracted pricing. We assume that this process will, in future, be part of each individual trust's discussion with NHSE/I on access to the new Financial Recovery Fund (FRF). But some might regard it as premature to remove this avenue for identifying a provider structural deficit before we can be sure that the FRF process will achieve a similar objective.

Questions for members on proposals 6 to 8

- Please let us know your views on proposal 6, and in particular, national prices being set as a formula, and the power for national prices to be applied only in specified circumstances.
- Please could you let us know of any occasions where you have applied to NHS Improvement to make local modifications to tariff prices and the result of this application.
- Do you have any further comments or concerns about these proposals?

Integrated care trusts

Summary of proposals

The integrated care provider (ICP) contract provides for a situation where local health systems wish to bring some services together under the responsibility of a single provider organisation, supported by a single contract and a combined budget. However, in some cases, it may be difficult for commissioners to identify an existing organisation that could take on responsibility for a contract of this kind. It could be that a group of local GP practices and a provider of community, mental health and/or hospital services wished to come together. However, the existing legislative framework doesn't lend itself to these circumstances as a new NHS foundation trust cannot be established from scratch and the 2012 Act did not envisage the creation of new NHS trusts. NHSE/I therefore propose that the Secretary of State be given the power to be able to set up new integrated care trusts.

PROPOSAL 9: Secretary of State to be able to set up new integrated care trusts

Integrated care trusts would only be established where local commissioners wished to bring services together under a single contract and where it is necessary to establish a new special purpose organisational vehicle to do so, and where there has been appropriate local engagement. The resulting ICP would:

- Have a contractual duty to deliver and improve health and care for a defined population
- Act as a provider of integrated care with the freedom to organise resources across a range of services
- Be run in a way that involves the local community and the full range of health care professionals

- Be accountable to commissioners for its performance

Taken together with the procurement proposals, this power to establish a new trust would also support the expectation in the long term plan that the ICP contract should be held by public statutory providers.

NHS Providers initial analysis

While we understand that this proposal could create some helpful flexibility within the system, we are cautious about its implementation. Whether created from existing entities or newly formed, establishing a new trust is a considerable undertaking. We need to be clear on when this would be pursued, and how this would be driven, and what consideration would be given to potentially valid alternatives (such as a merger). We would be keen to have assurances that new trusts would not be set up without the explicit support of all partners in the local health economy in question. There also need to be appropriate protections for existing NHS providers serving the area. There might, for example, be a possibility that the threat of creation of a new integrated trust could be used as leverage to get an existing trust to behave in a particular way. In our discussions with NHSE/I over this clause we asked for specific protection for providers but this has been translated as “appropriate local engagement”.

The duties, autonomy, governance and accountabilities of a new form of trust require careful consideration, not least since the proposal is to create a new type of trust rather than a foundation trust, and enabling vertical integration between secondary and primary care may mean establishing an organisation with a different composition from the current model. We will also explore how these trusts will be able to integrate services across a local system, with primary care particularly in mind.

Questions for members on proposal 9

- To what extent do you think this proposal presents your local system with an opportunity, particularly to develop more integrated models of care?
- What provisions or protections for NHS trusts and foundation trusts would you consider important as part of taking this proposal forward?
- Do you have any further comments or concerns about these proposals?

Mergers and acquisitions

Summary of proposals

In some circumstances, NHSE/I believe that plans to improve the management of local health services through mergers and acquisitions can be frustrated by the reluctance of one local trust to consider such a change. NHS Improvement can already direct NHS trusts in this respect. However, it can only take equivalent action in relation to NHS foundation trusts in the event of trust special administration – that is, where there is a serious failure or risk of failure.

PROPOSAL 10: NHS Improvement to have targeted powers to direct mergers or acquisitions involving NHS foundation trusts, in specific circumstances only, where there are clear patient benefits

NHSE/I are proposing that NHS Improvement should have the power to direct NHS foundation trusts to:

- Enter into arrangements to consider and/or to prepare for a merger or acquisition with an NHS trust or other NHS foundation trust
- Merge with an NHS trust or other NHS foundation trust
- Be acquired by another NHS foundation trust

Such an approach would change organisational accountability in a local system, and is distinct from changes to service provision. Decisions on service changes would remain a matter for local commissioners and providers, subject to national tests (such as strong patient engagement, preservation of patient choice, a clear clinical benefit, and support from local clinical commissioners).

NHS Providers initial analysis

In our view, any proposal for NHS Improvement to hold a broad power of direction over foundation trust mergers and acquisitions would cut across the ability of FT boards to carry out their responsibilities and be held properly accountable to the public for the quality of care they provide. That said, we know there are circumstances in which some members would welcome greater direction from the centre with regard to the structure of the local providers in their area, particularly if circumstances arise where one trust is unreasonably preventing a change in organisational form that every other member of a local system supports.

We have been debating the scope of this power with NHSI for some time. We argued that a general power to direct was wholly inappropriate. The proposals therefore talk about a targeted power for use in specific circumstances only. We recognise, however, that some members are likely to still have concerns.

We believe that greater clarity is needed as to the circumstances under which this power would be used (for example, how is the need for a merger or acquisition determined and how does NHS Improvement become involved). Would the power, for example, be more acceptable, if NHSE/I committed that it would only be used after a trust had been given the opportunity to determine for itself whether it was sustainable in a standalone form, and NHSI and all other providers in the area disagreed with the answer. It therefore feels important to explore alternatives have been considered, and whether would it be more effective and appropriate for NHS Improvement to hold a role more akin to arbiter in the event of local system dispute than director of that system).

This proposal also needs to be considered in conjunction with a number of other proposals. These include proposal 1, as the CMA would not have a role in investigating and intervening such changes; proposal 9, and the ability to create new integrated care trusts; and proposal 11, relating to NHS Improvement's direction of FT capital spending given the further impact on governance and control.

Questions for members on proposal 10

- We would argue strongly against a broadly drawn power for NHS Improvement to direct mergers and acquisitions on the basis that it interferes with appropriate trust autonomy and accountability. Please could you tell us:
 - If you agree with that stance
 - If there are alternative approaches to such a power, such as an arbitration role for NHS Improvement, which you would consider to be more helpful in your local system
 - The circumstances, if any, under which you would consider an 'in extremis use' of this power to be appropriate
- Do you have any further comments or concerns about these proposals?

Capital spending

Summary of proposals

There is an urgent need to invest in NHS buildings and facilities, and a more coordinated and collaborative approach to planning capital investment is required to support this. NHSE/I see that, while parliament approves an annual financial envelope for capital expenditure across the Department of Health and Social Care and the NHS, the lack of mechanisms to set capital spending for NHS foundation trusts is a barrier to a more collective approach. It can therefore be that, because of uncertainty around foundation trust capital spending, it is necessary to constrain or delay capital spending by trusts that may be more urgent or address higher priority needs. The inability of NHSE/I to control capital spend by FTs and, they argue, the inaccurate forecasting of such spend, also means that the risk of the NHS breaking its overall capital spending limit, is too great.

PROPOSAL 11: NHS Improvement to have powers to set annual capital spending limits for NHS foundation trusts

NHSE/I say they would want to avoid, where possible, cutting across the freedoms that FTs have to build up funding reserves or borrow money. The power to set annual spending limits would not prevent FTs from using their funding reserves for capital investment, but it would mean that they would need to agree with NHS Improvement, working with local health systems, when to make large capital investments.

NHS Providers initial analysis

Capital maintenance and investment is a key part of service delivery, and we question the circumstances under which NHS Improvement would be better placed to make a decision here than the trust board, especially bearing in mind that the consequences for under-investment will sit with the trust. Whilst we recognise the risks around breaking capital limits, we would argue that this risk has been elevated by the poor quality and opaqueness of the capital allocation process operated by NHSE/I and the Department of Health and Social Care. It is this, rather than trust failings, that is the largest contributor to inaccurate trust capital spend forecasting.

Subject to member views, NHS Providers intends to oppose this proposal. While appropriate controls over capital spending are necessary, we would question whether a legislative response which blurs trust autonomy and accountability is appropriate, especially when more proportionate and collaborative approaches could be pursued. For example, NHS Providers has argued for some time that a more robust capital bidding and prioritisation regime is needed in order to give trusts certainty over the coming years and frame their investments within a set of strategic priorities.

Questions for members on proposal 11

- Please could you let us know of any instances within your local system where there have been disputes around capital spending?
- Please could you let us know of any instances in your local area where NHS Improvement has used its powers in relation to NHS trusts (as opposed to NHS foundation trust) capital spending, and the results of this?
- What complications or opportunities do you foresee central direction of capital creating for your trust and/or local system?
- If there is a need for greater accuracy in forecasting capital expenditure to reduce the risk of exceeding the aggregate NHS capital limit, are there other ways in which this could be achieved that avoid the need for NHSI to have a power of direction over FT capital spending?
- Do you have any further comments or concerns about these proposals?

Provider and commissioner joint working

Summary of proposals

NHSE/I want NHS organisations to work with each other as ICSs to jointly plan and improve care delivery. However, they believe that establishing ICSs as distinct, new organisational entities would involve a complex reassignment of functions that currently sit with CCGs and trusts. Instead, they propose to change primary legislation to remove barriers to collaboration, and make legal provisions to allow CCGs and NHS providers to take joint decisions.

PROPOSAL 12: NHS providers and CCGs to be able to create joint committees

PROPOSAL 13: NHS England to be able to publish guidance on joint committee governance and appropriate delegation

Joint committees would not remove the existing responsibilities of CCGs and NHS providers. Joint committees would be required to act openly and transparently, and would need to work in a way that avoids conflicts of interests (for example, a commissioner would not be able to delegate to decisions on purchasing services to a joint committee).

NHSE/I also view it as sensible to allow NHS providers to form their own joint committees (CCGs can already do so). These could include representation from other bodies, such as primary care networks, GP practices or the voluntary sector. These committees could bring local care providers together to set up clinical services networks, a single estates strategy or shared IT, HR and pharmacy services.

Legislation currently specifies that CCG governing bodies must include a registered nurse and a doctor who is not a GP, neither of whom should be working for a provider where the CCG has commissioning arrangements. NHSE/I view it as inconsistent to allow GPs to sit on governing bodies but prevent the designated nurse and doctor from working for other local providers, and see this rule as too limiting for CCGs to plan services effectively.

PROPOSAL 14: allowing CCGs more freedom to have governing body members who work as clinicians for local providers

Joint roles may be a way of improving integrated care. While joint appointments can already be made, NHSE/I recognise that the legislation is ambiguous and organisations can leave themselves open to challenge in the future for the appointments they make.

PROPOSAL 15: making provision for CCGs and NHS providers to make joint appointments

NHS Providers initial analysis

The NHS is clearly in transition from a system focussed on individual CCGs / providers to one focussed on integrated local health and care systems. In the absence of legislation creating local health and care systems as formal legal entities to replace trusts and CCGs, we recognise the potential power of joint committees to help speed this transition. We believe there are currently two main uses of the joint committee approach: to bring groups of providers together into a common decision making structure; and as a means of cross system decision making covering both CCGs and providers in more advanced local systems.

However, as we understand the current proposals, the creation of a joint committee would mean that a trust could then be bound, potentially against its will, to decisions made by that committee even while the trust retains its accountability for those decisions. There will be some who are concerned by such a lack of clarity over how responsibilities are held, not least given the level of risk managed at trust level. Others might also highlight the potential absence of challenge within this model, as otherwise provided by non-executive directors (NEDs) within a trust's unitary board. The value of NEDs is recognised – and has been consistently strengthened over time – within the governance codes for the private sector, and we would encourage the same within the NHS.

We are therefore keen to understand how different members see the balance of benefit / risk here, weighing up the benefit of being able to speed the transition to integrated local systems against the risk of losing the clarity of accountability of current unitary trust boards. NHSE/I's proposals provide the protection that the creation of joint committees is a matter for local discretion. It would be helpful to understand if this is sufficient protection or whether this needs further definition (e.g. what happens if one member of a local system refuses to accept a joint committee all other members of that system support).

Regarding steps to enable joint provider-commissioner appointments, while we recognise the intention here to support system working, we need to be equally mindful that the purchaser-provider split is being maintained. Whether and where a joint appointment creates conflicts for the incumbent, or blurs board accountability, needs careful consideration.

Questions for members on proposals 12 to 15

- Have you explored the creation of a joint committee? If so, for what purpose and to what benefit? Equally, have you tried and failed to set up such a committee and if so, why did it fail?
- Are there any circumstances under which you can envisage your trust creating a joint committee (in any given combination of other trust(s) or CCG(s))? And what protections do you think are needed?
- Have you sought to make any joint appointments with a CCG to date? If so, please could you outline the key considerations for your trust in doing so.
- Do you have any further comments or concerns about these proposals?

Shared duties for providers and commissioners

Summary of proposals

NHS bodies are already bound by strong duties to provide or arrange high quality care and financial stewardship as individual organisations. However, NHSE/I do not believe that these are sufficient to ensure local systems plan and deliver care across organisational boundaries in ways that secure the best possible quality of care and health outcomes for local communities.

PROPOSAL 16: a shared duty for CCGs and NHS providers 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

NHSE/I believe that this change would support the goal of strengthening the chain of accountability for managing public money within and between NHS organisations. The legal duties that currently apply might be amended or extended to ensure consistency and support this triple aim.

NHS Providers initial analysis

We suspect that whilst most members will be supportive of the policy intent of this proposal, some might have reservations about it being added to existing duties, even recognising that they may be refined in parallel. A shared duty in this manner might, to some, seem to be in tension with trust boards' accountabilities for their organisation and organisational delivery. Further general duties may generate conflicts and it may be prudent to re-emphasise existing legislation and its policy intent rather than adding an extra layer.

Questions for members on proposals

- If your existing duties remained as they are, do you foresee any conflicts arising from the addition of a triple aim duty shared across local systems, including with CCGs?
- Do you have any further comments or concerns about these proposals?

Joined up commissioning

Summary of proposals

Commissioning responsibilities are split across CCGs, NHS England and local authorities, meaning that public health, primary care, hospital care and specialist services are organised by different bodies. NHSE/I want to join up commissioning without major organisational restructuring.

PROPOSAL 17: removing the barriers that limit the ability of CCGs, local authorities and NHS England to work together and take decisions jointly

NHSE/I identify barriers to joined up commissioning as including:

- The inability of CCGs holding delegated functions (for example, commissioning primary medical care on behalf of NHS England) to then enter into formal joint decision-making arrangements for that function with neighbouring CCGs or local government (as this would constitute unlawful double delegation)
- The public health functions carried out by NHS England on behalf of the Secretary of State (such as national screening and immunisation programmes) cannot be jointly commissioned by NHS England and one or more CCGs, making it harder to take account of local issues
- CCGs working together cannot currently make joint decisions other than by formally merging.

PROPOSAL 18: (a) NHS England can allow groups of CCGs to collaborate to arrange services for their combined populations; (b) CCGs can carry out delegated functions as if they were their own; and (c) groups of CCGs in joint and lead commissioner arrangements can make decisions and pool funds across their functions

PROPOSAL 19: enable NHS England to jointly commission with CCGs, or delegate to groups of CCGs, the specific services currently commissioned under the section 7A agreement

These changes would empower CCGs to make joint decisions and promote integration, although NHS England would retain its overall responsibilities. NHS England would also be required to consult on any plans to delegate services to CCGs.

Services that form part of care pathways can include services commissioned variously by NHS England, CCGs or local authorities. For example, CCGs commission services for patients with kidney disease, NHS England for patients with kidney failure. Such splits can hinder efforts to organise care around the needs of patients, as has been the case in integrating specialist mental health services with community-based mental health and social care services. NHSE/I believe that CCGs should be more involved in decisions around specialised services, but the only mechanism currently available is for full responsibility for individual services to be transferred to all CCGs. Yet this would not be appropriate for services which need to be planned on a larger population scale.

PROPOSAL 20: NHS England can enter into formal joint commissioning arrangements with CCGs (and so support, for example, specialised commissioning arrangements)

NHS Providers initial analysis

NHS Providers has raised a number of concerns around fragmented commissioning pathways, especially relating to mental health and specialised services. We also note the success of pilots to transfer responsibility for specialised commissioning of some forensic mental health services to providers and the desire to speed up and extend this approach. We would therefore welcome steps to streamline commissioning and support improvements to patient care. We are also mindful of other concurrent changes taking place, particularly the closer working of NHS England and NHS Improvement with the appointment of joint regional directors, and the potential growing role for providers in undertaking tactical commissioning or lead provider roles. We will be interested to understand how powers would be shared between CCGs, local authorities and NHS England, and also to understand the impact of these proposals on the commissioner-provider relationship at every level. We will also urge that providers are appropriately consulted as CCGs work more closely together to promote service integration.

Questions for members on proposals

- If you have experienced joint commissioning by NHS England and a CCG, do you have any concerns arising from that process which may be relevant here? Have there been any benefits or lessons learned to feed into these changes?
- Do you have any further comments or concerns about these proposals?

National leadership

Summary of proposals

There are limits on how far NHS England and NHS Improvement can work together. For example, there is no provision to formally carry out functions jointly, there are constraints on sharing board members, and they have separate accountability arrangements to the Secretary of State. This causes unhelpful and cumbersome bureaucracy for both organisations. NHSE/I are instead looking to go further in speaking with one voice, setting consistent expectations across the health system, developing a single oversight and support framework, bringing together national work programmes, and using collective resources more efficiently.

PROPOSAL 21: NHS England and NHS Improvement should be brought together more closely beyond the limits of the current legislation, whilst clarifying the accountability to Secretary of State and Parliament

PROPOSAL 22: closer working should be achieved by: either (a) creating a single organisation which combines all the relevant functions of NHS England and NHS Improvement; or (b) leaving the existing bodies as they are, but provide more flexibility to work together, including powers to carry out functions jointly or to delegate or transfer functions to each other, and the flexibility to have non-executive Board members in common

At present, there are different legislative arrangements for the accountability between the Secretary of State and each of NHS England, Monitor and the Trust Development Authority. If a single body were created, accountability would need to be appropriately defined. Moreover, the Health and Social Care

Select Committee has recommended that all national NHS arm's length bodies (ALBs) act in a more joined-up way, particularly on priority areas such as prevention of ill-health and workforce education and training. Responsibility for these issues sits in different organisations, specifically Public Health England and Health Education England.

PROPOSAL 23: enable wider collaboration between ALBs by establishing new powers for the Secretary of State to transfer, or require delegation of, ALB functions to other ALBs, and create new functions of ALBs

NHS Providers initial analysis

These proposals are a further significant shift in the way the NHS is led at a national level, with important implications for trusts and their leaders. While increased coordination and consistency is welcome, there remain significant risks within this approach which need careful consideration. These include the importance of understanding provider needs, risks and the task set for them, as well as a proportionate approach to regulation and support which take account of continuing lines of provider autonomy and accountability. There are also some who believe that the formal merger of NHSE/I would create a single organisation that was too large to function effectively and, potentially, represented too great a concentration of power. We are therefore interested in members' views on whether full; merger or greater working together is seen as preferable. We will seek greater clarity around these proposals and how NHSE/I would envisage their future relationship with the sector, whether they are acting as a single or more aligned entity.

While there is a logic for giving the Secretary of State greater power to transfer responsibility between arms length bodies we would be keen to hear from members if they think such an approach would bring increased risks or disadvantages.

Questions for members on proposals

- What is important for your trust in its relationship with NHS Improvement to see maintained in the future closer working arrangements of NHSE/I?
- Where would you see increased coordination and alignment as most beneficial to your trust?
- Would you prefer to see NHSE/I to fully merge or work more closely together, and why?
- What risks or disadvantages can you see to the Secretary of State having greater power to transfer responsibilities between arms length bodies?
- Do you have any further comments or concerns about these proposals?

Our press statement

Responding to the consultation on proposed legislative changes, the chief executive of NHS Providers, Chris Hopson said:

"The NHS has spent the last five years trying to find ways to create integrated local health and care systems within a legislative framework based on competition and individual institutions. This isn't a straightforward

task. It adds risk, uncertainty and complexity to the job of frontline leaders already grappling with significant financial, demand and workforce challenges.

“As the service works to fulfil the ambitions of the NHS long term plan, it makes sense to review whether we can make enabling changes through legislation, recognising that there are other possible ways of addressing the tensions between the current legislative framework and the desired direction of future travel.

“It is vital that we consider any changes carefully, work through the detail and co-create any changes with those affected, as the Health and Social Care Select Committee has suggested. We therefore welcome NHS England’s and NHS Improvement’s first step in announcing this engagement exercise and their commitment to a process of co-production.

“We will consult NHS foundation trusts and trusts, but we think there are proposals here that the provider sector will welcome and find helpful. We will wish to explore with providers the cumulative effect of the proposals, and we will want to talk to our members about two particular areas.

“First, the principle of trust boards being completely accountable for all that happens within their trust, and having the appropriate power and freedom to discharge that responsibility effectively, is central to the way the NHS currently works. It is the key governance mechanism to manage the level of safety, clinical, operational and financial risk inherent in the frontline delivery of hospital, mental health, community and ambulance services. As much as we all support integrated care within local health and care systems, we must approach anything that cuts across this clear trust board accountability with caution. We will therefore want to look very carefully at the proposals for NHSE/I to take powers to direct trust level merger and acquisition activity and set their capital limits.

“The second is how we manage the transition from an NHS legal framework based on competition and individual institutions to one of collaborative, integrated local health and care systems. The changes proposed are targeted as they seek to avoid a wholesale restructure and another top down re-organisation. However, they do create something of a halfway house and we must ensure that this half way house would deliver more effectively for patients than what we currently have, and that it would be robust, appropriate and consistent. We will therefore want, for example, to carefully consider proposals such as joint committee decision making between commissioners and providers and the ability of the Secretary of State to create new integrated trusts in this context.”