

## Health and Social Care Committee: NHS long term plan – legislative proposals Submission by NHS Providers, March 2019

NHS Providers is the membership organisation and trade association for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS foundation trusts and trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate. NHS Providers has all trusts in membership and they collectively account for £84bn of annual expenditure and employ more than one million staff.

### Key messages

- We welcome and support the move to integrated local health and care systems. We also acknowledge that the current NHS legislative and regulatory framework does not fully support this direction of travel. We recognise that a complete re-write of the current legislative framework has not, at this point, been judged either feasible or desirable. Therefore we need to consider whether a set of carefully drafted and targeted legislative changes can help speed up a consistent move to integrated care. However, a proposed set of changes needs to pass the following tests:
  - It must have been fully scrutinised, including extensive consultation and collaboration with the NHS frontline, and work to avoid unintended consequences.
  - It must, demonstrably, be better than the alternative options, that is, using the existing legislative framework to drive the required integration and/or waiting for the time when we can recast the NHS legislative framework in its entirety. It is important to note how much can be achieved within the existing legislative framework.
  - Given this proposed approach seeks to amend the current legislative framework piecemeal, it must leave a clear and coherent legislative framework for NHS organisations to work within, with a strong commitment to good governance and clear lines of accountability.
- We would broadly support a number of the proposals made by NHS England (NHSE) and NHS Improvement (NHSI), but it is important to also consider the cumulative impact of the proposals, which we believe would be significant. In particular, the proposals do not just seek to enable greater local health and care integration, they also seem likely to significantly shift the balance of power between local health and care delivery organisations and the national arm's length bodies, strengthening national at the expense of local. We are concerned that this could negatively impact the local leadership, autonomy and innovation that are essential for the effective delivery of local health care services.
- The current legislative framework is based on the principle that NHS provider unitary boards are accountable for everything that happens within their trust. Unitary boards combine an independent perspective with detailed knowledge of the organisation in setting strategy and culture, overseeing the work of the executive and being accountable to stakeholders. Whilst we support the need to enable greater system working, we are concerned that some of the proposals would cut across the centrality of unitary boards, potentially blurring accountability and increasing the chance of governance failure.
- We welcome the engagement by NHSE/I on the proposals and the Committee's early scrutiny, and hope that the proposals will now go through the usual and proper channels for legislative

development. It may be that, following reflection on responses to the current engagement document, a white paper is warranted before the proposals are developed as a draft bill and further scrutinised by a public bill committee. While the changes are in some ways focused on amending technical details within the NHS' structures and ways of working, they nevertheless would have a significant effect on the spirit and letter of existing legislation and the public's understanding of NHS.

### **Key considerations in introducing NHS legislative changes**

1. The *NHS long term plan*, and the secretary of state, have been keen to argue that any legislative proposals should come from the NHS itself, rather than be politically driven, and that there should be a consensus in taking them forward. While it is unusual for arm's length bodies (ALBs) such as NHSE/I to propose legislative change, we welcome the engagement process that they are undertaking on these proposals and we support their goal of enabling integration and collaborative working in local health and care systems.
2. Our view is that these proposals, if enacted in legislation, would have far reaching consequences. They therefore need detailed, robust and transparent scrutiny. In particular, we note that the proposals introduce welcome potential for greater integration of local services, but they also entail significantly greater powers of intervention for the NHS arm's length bodies. We also need to consider whether alternative, non-legislative approaches or reliance on the existing legislative framework would, in some cases, be more reasonable and proportionate.
3. Health legislation is complex and often controversial. Where legislative change is the appropriate route, 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 the continuing wider legal framework and maintain its clarity and consistency.

### **The current legislative framework, including the role of the board in healthcare delivery**

4. Two pieces of legislation provide the foundations for the current NHS legal framework: the National Health Service Act 2006 and the Health and Social Care Act 2012, which itself substantially amended the 2006 Act. These are supplemented by a number of other pieces of primary and secondary NHS legislation and national guidance. Key amongst these are the Health and Social Care Act 2008, which established the Care Quality Commission (CQC) and required all providers to be registered with the CQC; and the Care Act 2014, which brought in new-style CQC inspections as well as the duty of candour, and allowed for regulations to set fundamental standards and the fit and proper persons test. The NHS is also subject to a range of wider legal requirements, most notably those relating to competition and procurement (drawn from both UK and EU law), and the Companies Act 2006, with the duties of directors in NHS legislation owing much to this robust and respected piece of legislation. Local government and social care are also subject to their own legal frameworks, including the Care Act 2014.
5. The current NHS legal framework is predicated on a purchaser/provider split, where decisions about resource allocation and commissioning are separate from the delivery of care:
  - a. At a local level, this is embodied by clinical commissioning groups (CCGs) with NHS trusts, foundation trusts and primary care providers acting as the main delivery mechanisms (alongside local authorities and partners in the independent and voluntary

sector). Frontline provider organisations are intended to have autonomy in how they deliver the care they are commissioned to provide, and are accountable locally and nationally for doing so, including through a system of risk-based regulation. The reasons for this autonomy are clear and long established. Locally led organisations are best placed to: understand and meet differing local health needs; manage the risk inherent in delivering front line health services; be accountable to the local communities they serve; and manage the large and varied workforce and budgets required to deliver complex local services.

- b. At a national level, the purchaser/provider split is mirrored by the separate existence of the NHS Commissioning Board (NHS England) and Monitor and the Trist Development Authority (NHS Improvement), with a key responsibility for the two organisations to agree national prices for care (the national tariff).
  - c. Local government operates a separate accountability model with an internal purchaser/provider split operated by the local authority itself with regard to social care provision.
6. The key underlying philosophical principle of the 2012 Act was to maintain a purchaser/provider split in health, and to place competition in the market as the primary driver of improvement in the system. However, in recent years the national strategic policy direction as expressed, for example, in the *Five year forward view* and the recent *NHS long term plan*, has been to emphasise the importance of local collaboration and integration over competition:
- a. Since 2016, NHS providers and commissioners, along with local authorities, have been asked to work more closely together within non-statutory bodies known as sustainability and transformation partnerships (STPs) and integrated care systems (ICSs). This collaboration has extended both vertically (with secondary care providers being asked to collaborate with primary and social care in their immediate geographical footprint) and horizontally (with providers asked to collaborate with other similar organisations in the wider STP/ICS footprint).
  - b. In recent weeks, NHS England and NHS Improvement have taken the decision to come together under a single chief executive (Simon Stevens) reporting to two chairs (Lord Prior and Baroness Harding). There has also been a trend in recent years away from acting at arm's length, and instead using regulatory powers to enforce performance management, albeit without a proportionate shift in accountability.

#### *The role of the board in healthcare delivery*

- 7. Central to the current NHS legislative framework is the role of the unitary provider board.
- 8. The provision of frontline secondary care services is highly complex. It involves managing significant risk, workforce and financial resource at scale in a constantly changing context. Successful and consistent delivery of high-quality patient care depends on a system of local organisations, with clear corporate governance and public accountability, working at different population levels. The system is made coherent and responsive by constant interaction between national ambitions, regulatory standards and oversight, and local decision making and community engagement. In this way risk is managed at an appropriate level and resources are allocated through the system on the basis of the principle of

subsidiarity, with provision of care designed, delivered and overseen as close as possible to the communities served.

9. Each part of the system, given its decision-making powers, needs to be held answerable and accountable for those decisions. For this to happen, an organisation (a body corporate) needs to be formed, led and overseen by its board. In terms of NHS provision, in the secondary and specialist care sectors, trusts and foundation trusts are public benefit corporations and have – as elsewhere in the UK economy – unitary boards. This means a single board of directors, comprising executive and non-executive directors (NEDs). The non executive directors lead in providing challenge and gaining assurance that the decisions taken by the board and delegated to the executives are effective and appropriate. All board members share collective responsibility for their organisation’s performance (hence a unitary board). In essence, and in law, the board is the trust and the trust is the board. Foundation trusts (FTs) have an additional layer of local accountability, with the involvement of members (people actively interested in their local FT and wanting to influence how services are run) and a council of governors formed of elected and selected individuals representative of staff, patients, the local authority and other local stakeholders. The governors appoint the FT chair and hold the NEDs to account for the performance of the board.
10. Evidence from the private and public sectors suggests that unitary boards provide the best vehicle for good corporate governance because they combine an independent perspective with detailed knowledge of the organisation in setting strategy and culture, in oversight of the work of the executive and in being accountable to stakeholders.<sup>1</sup> The fact that the unitary board is responsible and accountable for everything that happens within the trust brings vital clarity in an environment which contains a significant amount of risk. It is notable, for example, in both the Francis Report on Mid Staffordshire NHS Foundation Trust and the Kirkup Report on Liverpool Community Health NHS Trust, that both reports were able to clearly and simply identify that the trust board was accountable for all that had happened within the trust. Both reports were, though, unable to identify who was responsible for the oversight of that trust board, with responsibility confusingly dispersed between Monitor and the Trust Development Authority (now combined to make NHSI), NHS England, the CQC and the relevant CCGs.
11. There is no legal form, structure or system that can completely inoculate NHS organisations against failure. Organisations are led by people not systems or methodologies and, as in any industry, success is contingent on the cumulative behaviour of individuals. But good corporate governance provides a vehicle for the provision of sound leadership, clear direction and effective accountability. As its widespread usage across UK national life shows, the unitary board model provides a better prospect of good governance than any other model of governance, leadership and direction. It provides a forum to set and model positive values and behaviours. The duty on non-executive and executive directors alike to challenge means that strategy is thoroughly tested and vetted. It provides a mechanism by which executive directors can be supervised effectively and be challenged on the results they deliver and it provides a key means of successfully managing risk.
12. We believe this has two consequences when we consider any NHS legislative changes. First, we must ensure that the governance of whichever organisations delivering secondary care services (which account for the large majority of the NHS’ budget, staff and clinical risk) remains robust, with the unitary board as the key governance mechanism. Second, we need

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<sup>1</sup> See <https://nhsproviders.org/media/1057/we-need-to-talk-about-boards-boards-leadership-and-the-nhs.pdf> for further detail.

to consider how to use the unitary board mechanism when looking at governance for any new structures, organisations or service delivery mechanisms, for example those required in new integrated care models.

## **The combined effect of the legislative proposals**

13. In considering the proposals put forward by NHSE and NHSI, it is important to consider the combined effect of the proposals, not just each proposal by itself. Consideration of this aggregate impact then sets the context for consideration of the specific proposals.
14. We welcome the recent policy direction towards greater collaboration between health and care organisations within local systems, as well as the renewed focus on population health management. Trusts understand the potential benefits for patients and communities of integrating service delivery more effectively at the frontline, and of the potential to make more effective use of the collective resource within a wider local area such as an STP/ICS footprint.
15. Whilst we broadly welcome a number of the proposals, we are concerned that the proposals, in aggregate, have two potential, important, negative impacts:
  - a. The proposals do not *only* enable more effective, rapid, and consistent integration. There is also a danger that they increase the strength of NHS arm's length bodies ("the centre") at the expense of the autonomy of local health care delivery organisations. They give the national NHS bodies significantly increased powers of direction without an attendant increase in accountability.
  - b. In some cases, the proposals appear to cut across the central principle and importance of accountability of trust boards, creating a lack of clarity which adds to the considerable risk present in moving the power to make decisions further away from the point of service delivery. National bodies can never have the appropriate level of information or local knowledge to make decisions at a local level. The principle of subsidiarity is tried, tested and successful, but we are concerned that these proposals would move the NHS in the opposite direction.

## **The specific proposals**

### **Competition: NHS payment systems and procurement**

16. The proposals relating to payment systems and procurement need to be viewed together in order to take account of their combined impact. These are:
  - a. NHS Improvement and NHS England merging or having formal joint working arrangements
  - b. The national tariff being set as a formula rather than a fixed value, along with a power for national prices to be applied only in specified circumstances
  - c. NHS Improvement no longer having a power, once ICSs are fully developed, to make local modifications to tariff prices
  - d. The removal of the CMA as a backstop in reviewing contested licence conditions and national tariff provisions
  - e. Commissioners having discretion in whether to run a procurement process, instead being able to apply a best value test
17. The prices paid by commissioners to NHS providers for the treatments they provide are set by a national tariff with the opportunity for local providers and commissioners to agree local

modifications. These prices are fundamental to the successful operation of the NHS as a whole and the financial stability of individual trusts and CCGs. The tariff has, up to now, been set through explicit negotiation and agreement between NHS England (legally, the NHS Commissioning Board) and NHS Improvement (legally, Monitor and the Trust Development Authority), embodying the purchaser/provider split at a national level. The central importance of this national tariff to the successful operation of trusts and CCGs was recognised in the 2012 Act by giving those organisations the right to vote on the tariff each time it was set and the creation of the option of referral to the CMA (Competition and Markets Authority) in the event of disagreement.

18. We recognise that there are benefits of effectively dissolving the purchaser/provider split at a national level by bringing NHSE and NHSI together to operate as a single body. This will bring greater clarity and simplicity of decision making and accountability, reduce unnecessary duplication and avoid conflicting messages. However, providers are concerned that this removes what has, in some cases, been a valuable tension, creating balance within the system and ensuring that the differing commissioning and provision viewpoints are fully represented when key decisions are made on how risk and resources are managed in the NHS.
19. This concern is heightened through the proposals to remove the power of the CMA to review contested tariff provisions, alongside allowing NHSI and NHSE to set national prices as a formula rather than a fixed value and removing NHSI's ability to intervene in local price setting decisions. This could mean a tariff that, from providers' perspective, is financially unviable with no or reduced means of effective provider objection. We recognise that there may be ways of ensuring that providers' concerns are adequately considered – for example by NHSE and NHSI making commitments around how they would act on any tariff objections from providers. But we believe these proposed changes need careful consideration.
20. Providers recognise that when ICSs are fully formed the need for NHSI to make local price modifications should become less necessary. But, in many systems, local price modification is a matter for often complex and difficult negotiation between providers and commissioners. We think there is a good argument for retention of NHSI's power of intervention on local price modification, especially whilst the journey to integrated local systems is in train and potentially beyond that.
21. Many trusts will welcome a reduction in the burden of tendering created by the procurement rules. A lack of national clarity and support around procurement has partly driven CCGs to pursue extensive and extended processes. These have been burdensome and wasteful, unnecessarily disrupt the provision of high quality local services and mitigate against effective planning over the longer term, particularly for community and mental health trusts whose services are more regularly subject to tendering.

### **Integrated care trusts**

22. At present there is no vehicle to set up new trusts easily, whether integrated or not: new NHS foundation trusts cannot be established from scratch and the 2012 Act did not envisage the creation of new NHS trusts. While we welcome NHSE/I's aspiration to support more integrated models of delivery – particularly between primary and secondary care – the proposal to give the secretary of state powers to create new integrated care trusts raises the following questions:
  - a. Is this legislative change needed?

- b. What decision making, governance and accountability arrangements are intended?
  - c. What should happen where local partners are at odds with one another?
  - d. What capacity is there for this power being used by the ALBs or the secretary of state as either threat or punishment?
23. Trusts and their local partners can already collaborate and integrate services within the existing legal frameworks. Some have agreed to move forward with structural change – for example, both the Royal Wolverhampton NHS Trust and Northumbria Healthcare NHS Foundation Trust are two of a number of trusts that directly support a number of GP practices and employ their staff direct or through a joint venture. The vast majority pursue partnership models which allow multidisciplinary teams to co-locate and work together across the boundaries of primary and secondary care, or indeed of the NHS and social care. This has been done within the existing legislative framework.
24. The proposal is described as arising from 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, but where the commissioner struggles to identify a suitable organisation to take this forward. This proposal is intended to enable a vehicle for such a contract to be established.
25. Given the complexity and time taken to set up a new organisation at this scale and with this level of responsibility, it is appropriate to test other legal routes of achieving the same objective. For example, at present, it may be that, through the recently launched integrated care provider (ICP) contract, an NHS trust or foundation trust could effectively act as a ‘lead provider’ holding the contract overall and working with a range of local partners including public health and primary care. Another approach taken at the moment is for local providers to work under an ‘alliance contract’ to deliver similar outcomes.
26. However, as NHSE/I recognise, there may not always be a straightforward means of pursuing these routes. Some local areas may also see the cultural benefit of closer, structural integration, particularly with regard to bringing primary and secondary care closer together or using a new organisational form.
27. Therefore, while legislative change may not be strictly necessary, it seems likely to be helpful if, (a) good governance arrangements are properly taken into account in designing the model, (b) the creation of a new trust is locally driven and not imposed by the centre, (c) there is sensitivity to existing provision and the sustainability of the local system, and (d) it is not used as a tool to bypass the existing trusts or foundation trusts in the area.
28. Therefore, while seeing the potential for this proposal to create some helpful flexibility within the system, we are also cautious about its detailed framing and implementation. Creating a new trust would be a considerable undertaking, and it is important to build on existing organisational models and approaches. As NHS foundation trusts and trusts can already act as integrated care trusts (for instance, delivering acute, community, social care and in some instances primary care), it may be that the simplest and most effective approach would be to enable the creation of new foundation trusts, building in due consideration for local wishes and resources.
29. Finally, the proposal raises the question of addressing friction within local systems. For example, there is the possibility that the threat of creation of a new integrated trust – or of the proposed powers to direct mergers and acquisitions – could be used as leverage to get an

existing trust to behave in a particular way. Yet the success of the new trust would seem to depend on positive working relationships and we would be concerned that new trusts should not be set up without the support of all partners in the local health economy in question. Given the necessary accountable autonomy of NHS trusts and foundation trusts, it is part of their duty to satisfy themselves as to the integrity of proposed service provision. With this in mind, we are particularly keen to ensure any new provisions for the creation of new integrated care trusts rest on local consent of all the relevant parties, including commissioners and incumbent trusts.

### **Competition: mergers and acquisitions (M&A), including the new proposed power for NHSI to direct providers to undertake specified M&A activity**

30. NHSE/I are proposing to remove the role of the Competition and Market Authority (CMA) in reviewing NHS foundation trust mergers. NHS Improvement's duties relating to promoting competition would also be removed, and there is also a proposal for NHSI to have targeted powers to direct FT mergers and acquisitions in specific circumstances.
31. 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. Yet they have found the involvement of the CMA in many cases to add unnecessary duplication, cost and complexity into the transaction process. Although competition can have a valuable role to play in the NHS, it must be applied carefully and sensibly to the ultimate benefit of patients. Overall, we would welcome reviewing the role of the CMA in the NHS, with a view to removing or amending its role and so streamlining the transactions process.
32. However, we are concerned by the proposal to give NHS Improvement powers of direction here. It is fundamental to trust autonomy and accountability that the trust board should determine their trust's configuration – for example, through a merger or acquisition – is fundamental to its autonomy and, therefore, its accountability. It is inappropriate for such changes to be directed from above. It is mistaken and against all governance good practice to require a unitary board to undertake any activity with which it disagrees. It is impossible to hold a board to account if it has been forced to undertake a merger or acquisition that it believes is inappropriate and is not in the best interest of the trust or the community it serves.
33. We fully recognise that the provider landscape is likely to need to change in the coming years but – not least as these changes are likely to be locally contentious – the approach taken should be determined within the local system. If NHSI believes that any local system is inappropriately configured – for example there are too many trusts or a trust is unsustainable in its current form – then it should ask the system to address that problem, not seek to direct a solution from above.
34. Providers are concerned that giving NHSI a power to direct M&A activity will encourage a sense of inappropriate “top down map drawing” where NHSI seeks to determine the best local configuration, substituting its national level judgement for what should be a matter of local determination. To give one example, there is currently a national-level debate, following the Kirkup Report, about whether standalone community trusts are viable as a sustainable organisational form in the long term. The fact that two standalone community trusts have indicated that they believe they are no longer sustainable in their current form is cited as evidence that the organisational form, per se, is no longer viable. This is simply not true, as a number of different, successful, thriving, standalone community trusts demonstrate.

35. We recognise that there is the potential in some local systems for all but one organisation to want to pursue a reconfiguration and for the one dissenting organisation to act as a “block” to a much-needed change. We also recognise the need for a local system, with the support of the arm’s length bodies, to effectively resolve such a situation. We believe, however, that there are a number of different and more appropriate ways of achieving without giving NHSI an inappropriate power to direct M&A activity from above. These include:
- a. NHSI and NHSE exercising their normal system oversight relationship with the trusts in the system concerned;
  - b. NHSI seeking to use its regulatory powers of intervention, for example, questioning whether the trust board is adequately fulfilling its duties towards patient care and sustainability; and
  - c. In extremis, NHSI exercising its existing power to remove and replace board directors.

In particular, we believe that this last power is a significantly better in extremis power than the power to direct a reluctant board to undertake unwanted M&A activity. We recognise this sets a high bar for NHSI to pass, but we believe that is appropriate.

### **Directing capital spending limits**

36. Parliament approves an annual financial envelope for capital expenditure across the Department of Health and Social Care and the NHS. NHS Improvement currently has powers (acting on behalf of the secretary of state) to direct capital spending by NHS trusts, but it does not have parallel powers over NHS foundation trusts and is seeking to acquire them. The rationale is that the lack of mechanisms to set capital spending for NHS foundation trusts is a barrier to a more collective approach, and 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.
37. However, the anomaly in the current system is, in fact, the power over NHS trust capital investment, not the absence of that power over NHS foundation trusts. To discharge their accountability effectively, provider boards must have the appropriate powers. These include the powers to appoint their own directors, decide who to acquire or merge with, create their own annual operational and financial plan and determine the required level of capital expenditure to ensure safe provision of high-quality patient care.
38. This proposal fundamentally cuts across provider autonomy and therefore accountability. 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 given that the consequences for under-investment will sit with the trust and its board. It does not appear that the national bodies would be taking on additional accountability to balance this power to intervene and direct.
39. Whilst we recognise the risks around breaking capital limits, there is widespread agreement that this risk has been elevated by the poor quality and opacity 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 forecasting. For example, NHS Providers has argued for some time that a more robust capital bidding and prioritisation regime, with a clear set of rules and criteria, is needed in order to give trusts certainty they need to and frame their investments within a set of strategic priorities. These deficiencies

have been recognised in the creation, at HM Treasury's insistence, of a formal review of the NHS capital regime, to which NHS Providers has contributed. 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. It would seem particularly inappropriate to introduce such a power in advance of the new capital regime due to be created by the review of the current capital regime being created and implemented.

### **Provider and commissioner joint working**

40. To avoid a substantial restructure of the NHS at regional and local levels, NHSE/I are not proposing to create local health and care systems (whether STPs and ICSs or other footprints) as formal legal entities. Yet there remains a desire to recognise and accelerate the NHS' transition from a system focussed on individual CCGs and providers to one focussed on integrated local health and care systems. NHSE/I have therefore proposed to enable NHS providers and CCGs to form joint committees (and for individual NHS provider organisations to be able to form joint committees with one another) and to make provision for CCGs and NHS providers to make joint appointments.
41. This proposal differs from the prevailing approach which is based on committees-in-common – essentially two individual committees which meet at the same time. This is an approach that providers and commissioners have already adopted to support system working. It is key to understand that:
  - a. A committee-in-common, because it has two different committees meeting at the same time, clearly keeps authority and accountability with the original governance bodies from which the different committees are derived – in the case of providers, the unitary board.
  - b. A joint committee sets up a new decision making entity, with two potential consequences:
    - i. First, it can cloud which entity has ultimate power and accountability, potentially setting up rival sources of authority – in the case of providers, the joint committee or the trust board. This becomes particularly important when the joint committee makes decisions with which the unitary trust board might disagree.
    - ii. Second, depending on how the joint committee is constituted, the participants in the decision making can be very different, diluting the power and effectiveness of a full unitary board. For example, a joint committee is often composed of executive directors and, sometimes, a single non executive participant or an independent chair. This is very different, and potentially significantly less robust, from having ultimate decision power clearly resting with a full unitary board.
42. These distinctions might appear technical but they are potentially profound and far reaching. They arise in the absence of formally constituting STPs and ICSs as full statutory organisations with their own unitary boards at this point, and as workarounds are being used to enable and support system working. We understand the need for such workarounds, but it is vital that they do not compromise the integrity of existing trust governance.

43. It may be that some local partners are happy to explore the option of joint committees and seek to pool their sovereignty. However, we need to be mindful of the consequences. As we understand the current proposals, the creation of joint committees would mean that a participating organisation could then be bound to decisions made by that committee while still retaining its accountability for those decisions. Given the considerable risk managed by NHS trusts and foundation trusts, and in combination with the lack of clarity over how responsibilities are held, this presents a pressure on collective board responsibility and accountability.
44. In addition, we would also highlight the apparent absence of challenge within this model, as otherwise provided by 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.
45. The proposals provide the protection that the creation of joint committees is a matter for local discretion. This is very welcome and we would argue is essential. In scrutinising this proposal, it is important to seek clarification of the limits of local discretion (for example, what happens if one member of a local system refuses to accept a joint committee all other members of that system support).
46. Similarly, it remains to be seen how sustainable joint appointments between CCGs and providers can be, given the potential for conflicts of interest and duties.

### **Shared duties for providers and commissioners**

47. 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. They therefore propose to create 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. The legal duties that currently apply might be amended or extended to ensure consistency and support this triple aim.
48. Given the intention to enhance local collaboration, this is an understandable proposal. However, we would welcome clarification as to how existing duties will be revised as we are concerned to avoid any duplication or contradiction in the final approach undertaken.

### **Joined up commissioning**

49. 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. They have identified barriers 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).
50. NHSE/I also recognise that 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. 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, which would not be appropriate for services which need to be planned on a larger population scale.

51. NHS Providers has raised a number of concerns around fragmented commissioning pathways, especially relating to mental health and specialised services. We would therefore welcome steps to streamline commissioning and support improvements to patient care.
52. However, 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 also urge that providers are fully consulted and involved as NHS England and CCGs work more closely together to promote service integration. This is not least as providers hold the greatest expertise in many of the services under discussion, particularly for specialised care. Recent pilots to devolve responsibility for mental health specialised commissioning to networks of providers (working with CCGs to ensure locally-based 'wrap around' community care is available) have proven successful. This suggests that providers have a key role to play in helping lead this work.

## **National leadership**

53. NHSE/I are 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. As such they are seeking to come closer together than current legislation allows, as well as clarifying accountability to the Secretary of State and Parliament. They propose to achieve this by either (a) creating a single organisation; or (b) providing 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.
54. These proposals are a significant shift in the way the NHS is led at a national level. Increased coordination and consistency are welcome, but we should consider carefully the risks as well. These include the importance of understanding provider needs, risks and the size and nature of 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.
55. 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. Greater clarity is needed around these proposals and how NHSE/I would envisage their future relationship with the trust sector, whether they are acting as a single or more aligned entity.
56. NHSE/I also note that there are different legislative arrangements for the accountability between the secretary of state and each of NHS England, and NHS Improvement's underlying legal entities, Monitor and the Trust Development Authority. If a single body were created, these disparate functions would need to be amended and accountability would need to be appropriately defined. Moreover, recognising the Health and Social Care Select Committee's recommendations that the NHS arm's length bodies should act in a more joined-up way,

NHSE/I propose to 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.

57. While there is a logic for giving the secretary of state greater power to transfer responsibility between ALBs, careful analysis of how such a power should or would be used is needed. For example, it would give the secretary of state considerable direct influence on NHS organisation and structures. While some rationalisation of ALBs may be helpful, we must also be mindful of the tendency of different governments to reorganise the NHS. We also need to remember the original intention of creating NHS England in particular as a means of lessening the politicisation of the service. There is also the potential within this approach that principles of subsidiarity and risk-based regulation are eroded over time.
58. Between 1974 and 2015, the NHS was reorganised 20 times in 41 years. The creation of STPs in 2016 was arguably a further reorganisation in all but law. As the Institute for Government points out, performance tends to fall in the first two years of major structural reforms.<sup>2</sup> For the NHS to achieve the ambitions set, it needs an extended period of stability in which to embed relationships and ways of working.

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