The NHS's recommendations to Government and Parliament for an NHS Bill

September 2019

NHS England and NHS Improvement

The NHS's recommendations to Government and Parliament for an NHS Bill

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Summary of the NHS's recommendations to Government and Parliament

1. An NHS Bill should be introduced in the next session of Parliament. Its purpose should be to free up different parts of the NHS to work together and with partners more easily. Once enacted, it would speed implementation of the 10-year NHS Long Term Plan.

2. We now have a clear and strong consensus about what this Bill should and should not contain. Our recommendations directly reflect and respond to the Health and Social Care Select Committee's (the Select Committee) report and recommendations.

3. A highly targeted Bill would command widespread support from the public and the NHS. Conversely, we found minimal appetite for primary legislation that would now trigger yet another wholesale administrative reorganisation of the NHS.

4. The Competition and Markets Authority's (CMA) roles in the NHS, as provided for by the Health and Social Care Act 2012 (2012 Act), should be repealed. There is strong public and NHS staff support for scrapping section 75 of the 2012 Act and for removing the commissioning of NHS healthcare services from the jurisdiction of the Public Contracts Regulations 2015. Taken together, these changes would remove the presumption of automatic tendering of NHS healthcare services over £615k. Monitor's specific focus and functions in relation to enforcing competition law should also be abolished.

5. We agree with the cross-party Select Committee that we should find a better name for the 'best value' test. We propose that the future regime that sets rules about if and how the NHS goes out to procurement is co-produced with stakeholders including the NHS Assembly, and that it is published in draft alongside the Bill to inform Parliamentary consideration.

6. The new regime must ensure transparency. A range of factors must be considered including quality of care, integration with other services, patient choice, access and inequalities, and social value. We agree with the Select Committee that we must avoid services becoming 'an airless room', so protection of patient choice should be included in the Bill. There should continue to be independent recourse and oversight of patient choice by NHS England and NHS Improvement.

7. Given clear support, the Bill should also contain the specific flexibilities we originally proposed on tariff including the ability to set a 'blended tariff' using a national formula, rather than only being able to set a fixed national price. Taken together, the operation of the tariff changes and the new procurement regime would help respond to the Select Committee's recommendation to guard against the risk of introducing competition solely on price as opposed to quality.

8. A new 'triple aim' of better health for the whole population, better quality care for all patients and financially sustainable services for the taxpayer should be introduced, as reciprocal goals for NHS commissioners and providers alike. The NHS improves wellbeing as well as health, and as recommended by the

Select Committee, that goal should be appropriately reflected on the face of the Bill.

9. The triple aim duty should reflect the need to engage local communities and build on the existing duties of local authorities and CCGs to engage patients and citizens, to collaborate in the performance of their functions, to integrate care delivery, and to improve the health and wellbeing of residents. Successful implementation of the NHS Long Term Plan requires the NHS to forge strong links with its communities, citizens and local government partners, not just to improve the planning and delivery of NHS services, but to promote physical and mental health and wellbeing, support the design of healthy communities, tackle inequalities, connect people better to relevant local community assets, and act as anchor institutions. We did not hear of specific NHS legislative barriers that hinder community co-production. Instead it may be possible to embed the principles of community co-production more clearly within the main text of the NHS Constitution.

10. The Select Committee agreed that NHS commissioners and providers should be newly allowed to form joint decision-making committees on a voluntary basis, rather than the alternative of creating Integrated Care Systems (ICS) as new statutory bodies, which would necessitate a major NHS reorganisation. We propose that NHS England and NHS Improvement should not have any new and additional powers of intervention in relation to such committees beyond those that exist in relation to CCGs and NHS providers. The law should make it permissible for NHS England and NHS Improvement's regional teams to participate for example in relation to specialised commissioning. It is also important to note that we propose to maintain current statutory duties to assess and report on Clinical Commissioning Groups (CCG) performance, and to oversee providers, albeit in ways that better reflect system working and the new triple aim duty.

11. Joint committees should be flexible enough to serve two different and distinct purposes. The first purpose is to enable closer collaboration and decision making between separate providers. The second is to assist and further the work of ICS which will cover the whole of England.

12. Closer collaboration between commissioners and providers is essential for implementing the NHS Long Term Plan. Every CCG governing body must presently include a clinician from an NHS provider but only from outside that CCG's area. This restriction should be lifted. Closer collaboration and decision making between NHS commissioners and providers also brings increased risks of conflicts of interest which will need managing through updated NHS England and NHS Improvement statutory guidance. Application of the new procurement regime should continue to be reserved to the CCG and not be delegable to the ICS joint committee.

13. Whilst we are only making proposals for NHS legislation, we also agree with the Select Committee that closer collaboration with and from local government is needed. Health and Wellbeing Boards will continue to have an important role in assessing local needs and developing joint health and wellbeing strategies. And local authorities should not only be able but actively encouraged to join ICS joint committees. Their full membership would greatly assist implementation of the NHS Long Term Plan, whilst not introducing a new local

government veto over the NHS's discharge of its own financial duties: for example, in making budgetary decisions about how best to live within a system-level NHS commissioner and provider resource limit set by Parliament.

14. NHS England and NHS Improvement should develop statutory guidance on governance of ICS joint committees. To increase transparency, ICS joint committees should not only meet in public, as recommended by the Select Committee, but also hold an annual general meeting and publish an annual report. Their decisions would also be subject to scrutiny by Local Authority Overview and Scrutiny Committees.

15. Our targeted proposals to help join up NHS commissioning were strongly supported and should be included in the Bill.

16. The 2012 Act made provision for the repeal of the Secretary of State's power to establish new NHS trusts. Whilst this provision has yet to be commenced, the continued use of the NHS trust model was clearly not envisaged by Parliament. We propose that this is reversed, to support the creation of Integrated Care Providers (ICPs). In addition, we also support the recommendation of the Select Committee, that only statutory NHS providers should be permitted to hold NHS ICP contracts. This will only be possible once the NHS is outside the Public Contracts Regulations 2015. Part of the assurance process for letting ICP contracts should demonstrate (i) improved care for patients, (ii) value for taxpayers, and (iii) engagement with all relevant parties, and local buy-in and support, which does not necessarily mean complete unanimity. As the British Medical Association (BMA) rightly states, GP partners cannot be forced to give up independent contractor status and to do so must always be their own free choice. There are many ways in which GPs can collaborate with other providers, including through primary care networks.

17. NHS Improvement's proposed power to direct mergers between foundation trusts (FTs) was rejected by the Select Committee, NHS Providers and the NHS Confederation. It was also discussed, and not supported, by the NHS Assembly. It should not be included in the draft Bill.

18. The proposed power for NHS Improvement to set annual capital spending limits for NHS FTs should also be circumscribed on the face of the Bill as a narrow 'reserve power' only. Each use of the power should only apply to a single named FT individually and automatically cease at the end of the current financial year. The newly merged NHS England and NHS Improvement should be required to explain why use of the power was necessary; describe what steps it had taken to avoid its use; and also include the response of the FT. To ensure transparency, this information would be published.

19. NHS England and NHS Improvement should be permitted to merge fully, as requested by both their boards, and strongly supported in the engagement responses. Monitor and the Trust Development Authority should be abolished, with their functions added as necessary to the existing legislative basis of NHS England. In response to the Select Committee's recommendations, we are not requesting that the merged body has any new powers over local NHS organisations apart from the new highly circumscribed 'reserve power' in relation to capital.

20. The proposal to allow the Secretary of State the same kind of flexibility enjoyed prior to the 2012 Act to transfer or require the delegation of functions between national bodies received a mixed response, including from a number of those bodies such as the Care Quality Commission. The Select Committee said that the case was unclear, and that more detail – and safeguards – would be required should the Government decide to proceed. There is no consensus which enables us to recommend the original proposal be progressed.

21. The Royal College of Nursing (RCN) sponsored a petition calling for clearer accountability and enough funding to ensure sufficient staff in the NHS. UNISON and several medical royal colleges have also made the same points. In responding, we recommend that the Government should now revisit with partners whether national responsibilities and duties in relation to workforce functions are sufficiently clear.

22. Finally, we recommend that the Government adopts an inclusive process to preparing the Bill, prior to its presentation to Parliament. In this way, the strong consensus generated through our process, aided by the Select Committee, would be maintained.

1. How we engaged people

Introduction

1. On 28 February 2019, NHS England and NHS Improvement launched an engagement process on *Implementing the NHS Long Term Plan: Proposals for possible changes to legislation*[1]. This built on proposals outlined in the NHS Long Term Plan[2] in January 2019 and invited views from across the health and care system, including patients, staff, NHS leaders and our partner organisations.

2. In setting out our proposals, we made it clear that the NHS Long Term Plan can be implemented without primary legislation. But legislative change could make implementation easier and faster. We also set out three guiding design principles based on what we had heard in discussions about the NHS Long Term Plan:

    - any legislative changes must solve practical problems the NHS faces
    - they should not constitute another top-down reorganisation, likely to create operational distraction that slows the pace of reform
    - any proposals for change should enjoy a broad consensus from across the NHS and its partner organisations

3. A unifying theme of our proposals was to make it easier to integrate care and for NHS organisations to work together in the interests of patients. We set out a range of proposals aimed at: reducing the overly bureaucratic impact of current competition and procurement requirements; placing a stronger shared responsibility on NHS organisations to work in the interests of their local system and for the wider NHS; making it easier for organisations to work together in planning and delivering care; and enabling more joined-up national leadership.

4. The Parliamentary cross-party Select Committee for Health and Social Care launched an inquiry in parallel with our engagement process and reported their findings on 24 June 2019[3]. Their findings welcomed the majority of the proposals, recognising them as a pragmatic set of reforms aimed at removing the barriers to integrated care.

5. This paper outlines the response to our engagement process and recommendations made by the Health and Social Care Select Committee and makes a series of recommendations to Government for legislative change in light of what we have heard.

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[1] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/02/nhs-legislation-engagement-document.pdf
[2] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf
[3] https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/2000/2000.pdf

6. Earlier this year, the Boards of NHS England and NHS Improvement decided to work more closely together, whilst ensuring clarity about which decisions are formally made by which body. Throughout this document we refer to “NHS England and NHS Improvement” as representing the shared views and collaborative working of NHS England and NHS Improvement.

The engagement process

7. NHS England and NHS Improvement have carried out an extensive engagement process. Launched on 28 February 2019, the engagement document was accompanied by a survey that sought views on each of the individual proposals and could be completed online or returned in hard copy by post. In addition, respondents could respond separately on any of the proposals or additional issues they wanted to raise via a central NHS England and NHS Improvement e-mail address.

8. The formal engagement process closed on 25 April 2019. The written response was significant. 192,806 individuals, or organisations representing different parts of the health and social care system, responded in writing to the engagement document. Specifically, there were:

    - 624 responses to our online survey, clearly setting out a position of agreement or disagreement on our proposals
    - 82 further written responses from organisations and individuals providing detailed feedback
    - 173,750 individual responses via the online campaigning organisation 38 Degrees responding to Chapter 2 in the engagement document – specifically in relation to section 75 of the Health and Social Care Act 2012 (2012 Act) and what should be considered as part of the proposed “best value test”
    - 9,807 e-mails forming a petition to seek additional measures in legislation on accountability for nurse staffing, supported by the Royal College of Nursing
    - 8,543 e-mails from “Keep our NHS public” supporting the repeal of section 75 of the 2012 Act

9. By far, the biggest proportion of these responses came from individuals identifying themselves as a member of the general public, patient, NHS staff, carers or as a healthcare professional. Respondents from a much broader field also responded including local authorities, NHS national bodies, commercial organisations, independent provider organisations and trade unions.

10. In addition to the written engagement, NHS England and NHS Improvement ran over 30 targeted roundtable discussions and webinars with NHS and local authority staff, representative bodies and leaders, voluntary groups, and

community organisations. There were also two national events held in Leeds and London attended predominantly by local commissioners and providers and other sector representatives.

11. The Health and Social Care Select Committee inquiry also took oral evidence from a range of representatives, including NHS England and NHS Improvement. Evidence given as part of the inquiry recognised the opportunity and inclusion felt through the NHS England and NHS Improvement engagement process, especially on those areas impacting specific individuals or organisations.

12. NHS England and NHS Improvement have also benefited from ongoing engagement and discussion with a wide range of stakeholders following publication of the Health and Social Care Select Committee's 24 June report. We further tested our recommendations and understand a number of organisations are writing to the Secretary of State to express support.

Key themes

13. The volume and breadth of the response demonstrates the close association and strength of feeling people in England have for the NHS. Throughout the response there was overriding appetite for the main theme of the proposals - that the NHS and its partners should be allowed to operate more collaboratively and in an integrated manner.

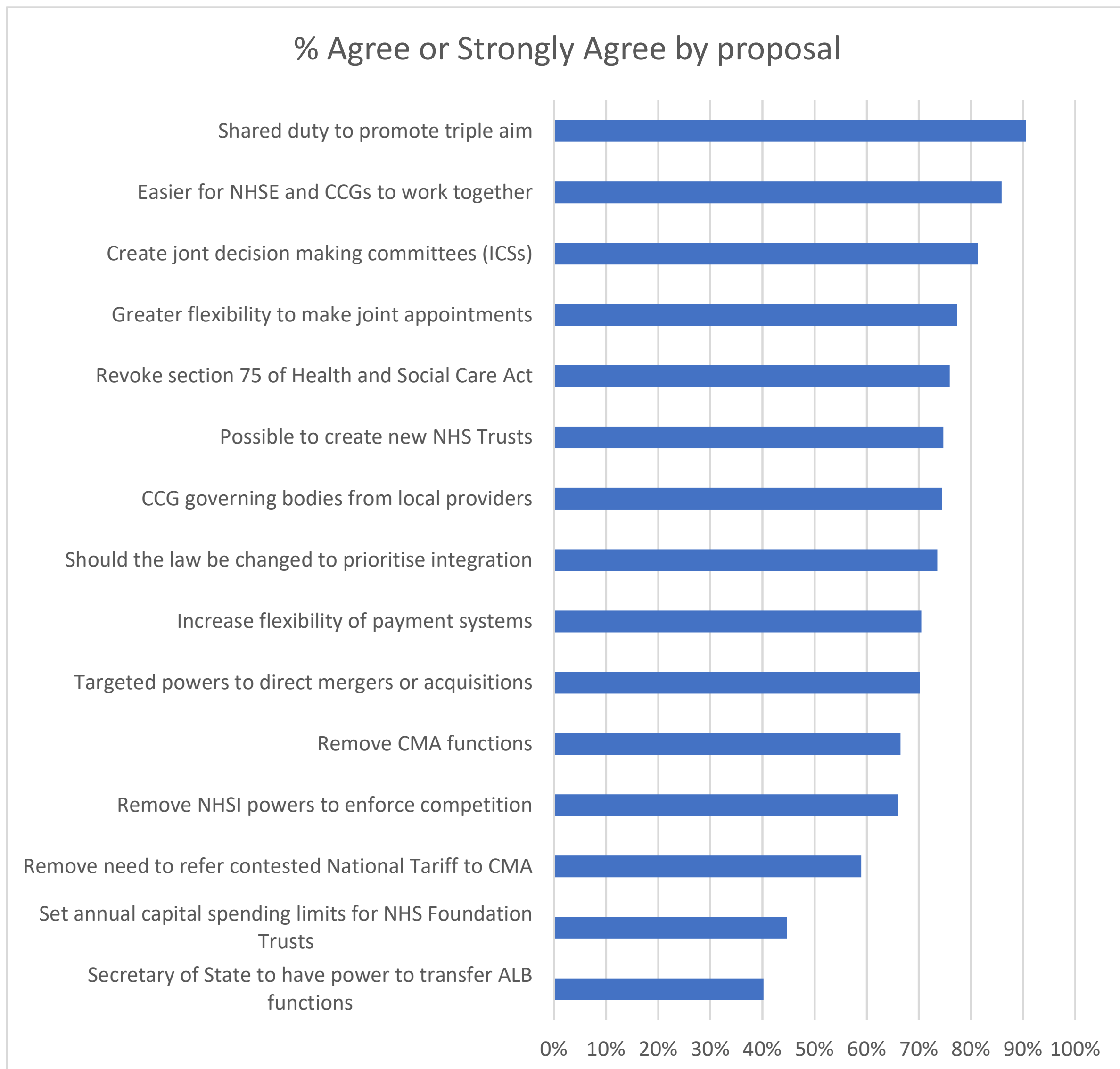
14. Our engagement survey asked only one compulsory question: *"Should the law be changed to prioritise integration and collaboration in the NHS through the changes we recommend?"*. Of the 624 online respondents, 73.5% stated that they either agreed or strongly agreed it should. 11.1% were neutral with only 15.4% in disagreement with the principle.

15. The level of agreement in response to this question (as well as the level of support for our individual proposals) indicates a broad and strong consensus from within the NHS and beyond in support of our targeted package of legislative proposals.

16. The question of a targeted versus an omnibus Bill was explored during oral evidence to the Health and Social Care Select Committee and at national events as part of the engagement process. We saw a clear depth of opinion that we should avoid wide-ranging legislative change that would lead to major, top-down administrative reorganisation, because that would distract from and slow down delivery of the NHS Long Term Plan.

17. Our online survey asked for views on each of our proposals for legislative change. A summary of support for each of the different proposals is set out in the illustration below with a more detailed analysis of the responses attached in

the annex. The overall message is clear: there is strong support for the majority of our proposals.



18. In the following chapters, we look at the responses in more detail in relation to each of our proposals. Whilst overall our proposals have attracted strong support, a small number of important specific proposals divided opinion. We also heard requests for greater clarity about how they would work in detail – some of which are matters that would be answered either through the drafting of the Bill and its explanatory notes, or associated statutory instruments, or through operational guidance.

19. In particular:
    - Whilst there is strong support for our proposals to free the NHS from existing, rigid procurement arrangements, respondents want to see more detail as to how our proposed ‘best value’ duty would work and avoid the NHS becoming an ‘airless room’ (i.e. where decisions are made by NHS organisations alone in their own best institutional interests, without reference to the views and preferences of patients, citizens and partners)

- Our proposals for limited new powers over NHS foundation trusts have proven the most contentious. The Health and Social Care Select Committee, NHS Providers and the NHS Confederation did not support the proposals as originally set out
- People wanted to see a stronger focus from the NHS on co-production with local communities, and on joint working with local government. It is also recognised that these goals may not be achieved through legislative changes alone
- We recognise from the responses we have received (as well as discussions at the Select Committee) that we need to explain more clearly how accountability and transparency will work at a local and national level in the context of the more collaborative arrangements we are proposing (in particular, joint committees)

20. These issues are considered further in the following chapters. In our survey we asked respondents whether they had other comments. We received a broad range of further comments and additional proposals for legislative reform from both stakeholder organisations and individuals.

21. Given the significant volume and breadth of comments on a range of issues and proposals, we have not been able to address every single one in this document. We are mindful that a number of stakeholders raised specific policy questions that were not obviously matters for primary legislation and that were not directly connected with implementing the NHS Long Term Plan. In this document we have focused on analysing and responding to what we heard about our proposals and responding to the Health and Social Care Select Committee's recommendations.

2. Promoting collaboration

Our original proposals

22. We invited views on three proposals which would:
    - remove the Competition and Market Authority's (CMA) function to review mergers involving NHS foundation trusts
    - remove NHS Improvement's specific functions in relation to competition
    - remove the need for NHS Improvement to refer contested licence conditions or National Tariff provisions to the CMA

23. Our rationale was to create a more nuanced approach that gives due weight to collaboration. The CMA has powers to investigate alleged infringements of competition law and particular markets if it sees issues for consumers with reducing competition. The CMA has used these powers – for example in relation to the pricing of pharmaceuticals – to protect the public interest. We said we saw clear benefit in the CMA continuing this role.

24. However, the CMA's merger control regime applies to proposed NHS mergers involving NHS foundation trusts and the CMA has led a number of investigations into NHS foundation trust mergers or acquisitions in recent years. We questioned the value of these investigations on the basis of the cost and time consumed for the organisations involved. Instead, as a result, we proposed to remove the CMA's functions to review mergers involving NHS foundation trusts, NHS England and NHS Improvement would continue to review proposed transactions between trusts, including mergers or acquisitions, to ensure there are clear patient benefits.

25. In addition, we saw NHS Improvement's primary role as supporting improvement in the quality of care and use of NHS resources. In line with this, we proposed that NHS Improvement's specific competition functions should be removed. NHS England and NHS Improvement would continue to be responsible for setting conditions for those healthcare providers (including NHS foundation trusts and independent sector providers) that are required to hold an NHS provider licence.

26. NHS England and NHS Improvement (as Monitor) are also responsible for the National Tariff Payment System, which governs the payments that NHS commissioners make for NHS-funded care (other than primary care). Under the 2012 Act, where a sufficient number of relevant bodies object to proposed licence conditions or the proposed method for determining prices under the National Tariff Payment System, NHS Improvement must either refer the relevant proposals to the CMA or consult on a revised set of proposals. Our engagement document proposed that NHS England and NHS Improvement should be able to reach final decisions on these matters without referral to a

competition authority. We therefore also proposed that the current provisions for NHS England and NHS Improvement to refer contested licence conditions or National Tariff provisions to the CMA should be removed.

What we heard

27. Many organisations, ranging from the Trades Union Congress (TUC) to individual NHS foundation trusts said that the CMA was not the right body to make decisions about the NHS, whether it be in reviewing mergers or licence conditions and tariff.

28. Most respondents suggested that the NHS itself was capable of making decisions about its own functions, particularly in the context of setting licence conditions, while others thought that any arbitrator, whether independent, or part of NHS England and NHS Improvement, should have specialist NHS knowledge and share NHS values.

29. Regarding merger reviews, Mid and South Essex STP noted that: *"the CMA process has added complexity and cost into what is already a heavily regulated process that have detracted from these core principles and delayed progress to improve services for our population… We consider it appropriate that NHS Improvement, with its core focus on quality and service improvement, would still have oversight on merger applications and processes."*

30. The Health and Social Care Select Committee welcomed the broad thrust of the proposals, believing that *"collaboration, rather than competition, as an organising principle, is a better way for the NHS and the wider health and care system to respond to today's challenges."*

Survey proposal	579 responses
1a	Remove the Competition and Markets Authority (CMA) function to review mergers involving NHS foundation trusts

31. Of those individuals and organisations who responded to this question via the online survey, 66.5% agreed or strongly agreed with the proposal, with only 19.5% disagreeing or strongly disagreeing. 14% of respondents were neutral towards the proposal.

32. Overall, the detailed written responses demonstrated support for the proposal and recognition that the CMA is not the right body to be considering NHS mergers. Respondents comments included:
    - *"… the CMA's strict application of competition principles, based on its experience of regulating private companies, was a poor fit for its role overseeing NHS transactions. Many felt that 'public interest' or 'public value' had never been at the heart of CMA decision making and they suggested that the CMA approach did not take taxpayers' interests enough*

into account by making sure services are provided as efficiently as possible." (NHS Confederation)

- *"Removing, or at least significantly reducing, the role for the Competition and Markets Authority in healthcare would be a welcome move."* (UNISON)
- *"The CMA adds a layer of bureaucracy that is unnecessary, time consuming and costly."* (Birmingham and Solihull STP)
- *"Competition is not the main driver of quality improvement (and efficiency) in the NHS"* (The Royal Bournemouth and Christchurch Hospitals NHS FT)

33. The Health and Social Care Select Committee findings also welcomed the intention behind removing the Competition and Markets Authority's NHS-specific role in overseeing mergers involving NHS foundation trusts. The Committee also asked whether *"to remove foundation trusts entirely from the CMA's remit would require the law to change so that foundation trusts are no longer considered as 'enterprises' under the Enterprise Act"* and consequently they recommended that the Department of Health and Social Care, together with NHS England and NHS Improvement, seek advice on the changes that might be required to remove foundation trusts from the CMA's jurisdiction and the implications of doing so.

34. Concerns about the proposal focused on the potential for NHS providers to act in a monopolistic way, limiting the scope for other providers to offer services and thereby reducing patient choice:
    - *"[Risk of] a concentration of services only being delivered by NHS organisations rather than by other NHS providers such as social enterprises and existing mutuals."* (Employee Ownership Association)
    - *"Choice (which requires a diversity of provision) has been identified as a factor which may support good patient outcomes in hearing aid provision. We would therefore urge that monitoring arrangements are implemented to assess the impact of closer collaboration and reduced competition on a range of services."* (Action on Hearing Loss)
    - *"In principle … we support greater collaboration within and across health and care, provided it continues to allow for patient choice and takes into account the need to continue to ensure access to services for vulnerable and rural populations."* (The British Red Cross)

35. Responses highlighted the need to continue to oversee transactions, to ensure they are in the interests of patients:
    - *"There must be demonstrable benefits to service delivery and patient care that can be achieved from any merger or acquisition for it to be approved."* (Employee Ownership Association)
    - *"If NHS Improvement are to take sole responsibility in this area they must focus on patient benefit above all else, and if no patient benefit is found, mergers must be rejected"* (Parkinson's UK)
    - *"It is important for long term sustainability that an appropriate balance is maintained between the benefits of integrating vs. the benefits of*

maintaining patient choice and competitive tension. What will the system safeguard be in place of this to ensure some Trusts / Commissioners divert activity without concern for patient choice or the impact on quality of service?" (The Royal Marsden NHS FT)

- *"Measures that will streamline processes for Trusts to come together where there is compelling evidence (particularly clinically) it will bring benefits are welcomed."* (Wolverhampton CCG)
- *"Patient benefit needs to be the key consideration for any mergers involving NHS organisations"* (Leicestershire City Council)

36. A small number of responses raised concern that removal of the CMA provision, if combined with the other original proposals on forcing mergers and controlling capital spend, would lead to centralisation:
    - *"With regard to the CMA – we do not believe this body should have a role in the NHS but are wary of removing the review of mergers without this role being carried out by another and more appropriate body."* (North East London Save our NHS)
    - *"… while members supported the idea of removing CMA's role in mergers and acquisitions, some were worried that it would lead to a further concentration of power in the hands of NHS England/NHS Improvement. This was of particular concern when the plans to remove the CMA's role is combined with the proposal to give NHSI/E legislative powers to direct mergers and acquisitions in specific circumstances. … Ideally, we need the revised legislation to set out clearly how organisations would be able to challenge decisions and how any further arbitration process would operate. Additionally, we need to make sure decisions are made in the interests of patients, and with patient interest clearly defined."* (NHS Confederation)

Survey proposal	577 responses
1b	Remove NHS Improvement's competition powers and its general duty to prevent anti-competitive behaviour

37. Of those individuals and organisations who responded to this question via the online survey, 66.1% agreed or strongly agreed with the proposal, with only 18.8% disagreeing or strongly disagreeing. 15.1% of respondents were neutral towards the proposal. Opposition or neutral responses exceeded or equalled support from those identifying themselves as GPs, independent provider organisations, and industry bodies, although sample sizes for these groups were small.

38. In responding to this question, most responses emphasised the need to focus more on collaboration rather than competition as a driver for service improvement:
    - *"Competition has inhibited the development of more innovative responses to the health needs of the population. It doesn't help to encourage joint and*

collaboratively working between providers to the detriment of the patient experience." (Hertfordshire County Council Health Scrutiny Committee)
- *"I would like the CMA to have no role in relation to the NHS, and for NHSI's competition powers to be subordinated to its promotion of collaboration between NHS organisations."* (individual health care professional)

39. A number of responses recognised a role for competition where it could lead to better outcomes for patients: *"competition should be encouraged where it can lead to better outcomes for patients, but not as an end in itself*'(Bedfordshire, Luton and Milton Keynes ICS). A number of responses emphasised the importance of provider licence conditions and patient choice as safeguards against adverse institutional self-interest:
    - *"Important decisions around mergers, licence conditions and the national tariff should properly rest within the NHS"* (UNISON)
    - *"Cartels of NHS trusts may form which block access or reduce the role of social enterprises which are delivering high quality services…We recommend that the general duty to prevent anti-competitive behaviour is replaced with a general duty for NHS Improvement to ensure that collaboration is balanced with ensuring that there is fair opportunity for social enterprise providers (existing and new), voluntary organisations and other providers to participate in the delivery of services."* (Integrated Care 24, Social Enterprise Provider)
    - *"We agree but would wish to see some safeguards put in place and that there is an appropriate appeals mechanism"* (Ashford and St Peters NHS FT)
    - *"Through licence conditions, NHSI (Monitor) would continue to prevent anti-competitive behaviours that were not in the best interests of patients"* (Mid and South Essex STP)
    - *"Helping NHS organisations to avoid competition law concerns should help with provider consolidation. But there is also potential risk for a detrimental effect on patient choice as a result."* (The Rotherham NHS FT)
    - *"Patient interest will remain protected by prohibition on anti-competitive behaviour in the Licence."* (Greater Manchester Health and Social Care Partnership)

Survey proposal	576 responses
1c	Remove the need for NHS Improvement to refer contested licence conditions or National Tariff provisions to the CMA

40. Of those individuals and organisations who responded to this question via the online survey, 59% agreed or strongly agreed with the proposal, with only 16.2% disagreeing or strongly disagreeing. 24.8% of respondents who responded were neutral towards the proposal.

41. Of the 34 formal responses from providers who hold a provider licence or their representative bodies, only seven showed opposition to the proposal. Other

provider respondents, including NHS foundation trusts and independent providers, called for assurances and detail around safeguards, but expressed general support, or neutral positions, on the proposal.

42. Of those respondents who provided commentary with reference to the specific proposal,19 raised questions about what safeguards would be established to provide independent review or arbitration were the right to refer to the CMA removed, including five who specifically questioned what legal recourse might be introduced.

43. Several respondents wanted assurance around the safeguards that would be established to protect providers from any future risk of imposition of unreasonable licence conditions.

44. Some respondents wanted clarification on how objections would be considered. For example, University College London Hospitals NHS FT noted that: *"we agree that removal of the need for contested national tariffs or licence conditions to be referred to the CMA would streamline the current process provided that there is reassurance in the form of a clear guarantee of what NHSI/NHSE means when it says it will seriously consider any objections."*

45. Other respondents, including large independent providers, argued that there must be sufficient engagement and scrutiny over contested licence conditions or tariff provisions.

46. Greater Manchester Health and Social Care Partnership suggested that the desire for some form of safeguards, and the recognition that the NHS are capable to make their own decisions, are not mutually exclusive: "*We would agree that NHS England and NHS Improvement together would be better placed, and capable, of resolving any objections to proposed licence conditions or National Tariff provisions. It would be important in that context however to ensure that clear gateways/decision making process will be available through NHSE/I if dispute does arise. Assurance would be required, therefore, that legitimate provider concerns will receive due consideration."*

47. These points were also echoed by the Health and Social Care Select Committee who supported the proposal to remove the need for NHS Improvement to refer objections on the national tariff and provider licence conditions to the CMA. However, they recommend that the Department, NHS England and NHS Improvement should *"build in a mechanism for independent adjudication of challenges to these decisions."*

48. By contrast, the Trades Union Congress felt that a consultation process was sufficient. *"… we do not believe that an external competition regulator like the CMA should have powers over key strategic decisions around mergers, licence conditions and the national tariff. We agree that these powers should reside*

solely within the remit of NHS Improvement, subject to a relevant consultation process where appropriate."

Recommendation 1: Remove the Competition and Markets Authority (CMA) function to review mergers involving NHS foundation trusts

49. Overall, responses to the engagement exercise support this proposal. We note the concerns raised about the potential impact on patient choice. Recommendations later in this report set out how we propose to strengthen patient choice requirements through legislation. We also propose to retain as a further safeguard (as set out below for Recommendation 2) NHS Improvement's power to set licence conditions in relation to choice.

50. The 2012 Act should be amended so that where two NHS foundation trusts or NHS trusts merge (including where one trust is acquired by another) that is not subject to the CMA's merger regime under the Enterprise Act.

Recommendation 2: Remove NHS Improvement's specific competition functions and its general duty to prevent anti-competitive behaviour

51. NHS Improvement's primary role is to support improvement in the quality of care and use of NHS resources. It is not an economic regulator, overseeing a commercial market. Responses to our engagement document support this view. In line with this, we propose NHS Improvement's general competition powers and duties should be removed.

52. We propose that NHS Improvement's ability to set licence conditions relating to choice and competition is retained. This would provide a safeguard against the risk that providers could develop models which are not in patients' interests.

53. We expect that these licence conditions would seldom be subject to formal enforcement action. It is significantly easier to adapt the choice and competition licence conditions to the unique needs of the NHS than is possible under the powers NHS Improvement holds concurrently with the CMA, where substantive tests are set out in primary legislation and where there is a substantial body of case law and precedent. We will consider whether it would be appropriate to amend the existing licence conditions that are made under this provision and/or issue new guidance to reflect this.

54. Under our proposals, NHS Improvement would no longer have general competition law powers to enforce the Competition Act 1998, or to conduct market studies or make market investigation references under the Enterprise Act 2002.

Recommendation 3: Remove the need for NHS Improvement to refer contested licence conditions or National Tariff provisions to the CMA

55. We believe that NHS England and NHS Improvement should be able to make its own decisions about licensing conditions. The NHS needs to hold itself collectively responsible for achieving effective, efficient and high-quality care. Removing the powers of the CMA in this context ensures that decisions remain in the interest of the NHS as a whole.

56. We would retain the explicit duty to consult on proposed changes to licence conditions. The relevant decisions would continue to be subject to ordinary public law requirements to give proper consideration to consultation responses and to follow the public law principles of fairness, legality and rationality.

57. We have considered replacing the current arrangements for referral to the CMA for determination with another statutory mechanism for considering objections, such as to a newly created body or tribunal. We do not support this.

58. NHS England and NHS Improvement's accountability arrangements to the Secretary of State and Parliament offer a safeguard against disproportionate changes to licence conditions.

59. At the engagement events some participants also said that whilst they supported the proposal to remove the ability for NHS Improvement to refer contested national tariff provisions to the CMA, they wanted to see meaningful engagement and consultation retained as a feature of tariff development.

60. We would retain the explicit duty to consult on proposed changes to tariff. The relevant decisions would continue to be subject to ordinary public law requirements to give proper consideration to consultation responses and to follow the public law principles of fairness, legality and rationality. As now, providers and CCGs would be able to object to the method for calculating national prices proposed by NHS England and NHS Improvement. If "objection percentage" thresholds are exceeded, we propose that NHS England and NHS Improvement must discuss the issue with representatives of the objectors and publish a response to the objections stating whether it is to: (i) revise the proposals and re-consult; or (ii) retain the current proposals. If the latter, NHS England and NHS Improvement must set out its reasons for proceeding.

61. We would also continue to engage with providers and commissioners before the statutory consultation process to discuss proposed changes to the tariff. This engagement is done through meetings with groups of providers, commissioners and representative groups and the publication of an engagement document where we seek feedback on proposals before publication of the consultation document.

62. The many safeguards described above, including repeated obligations to engage and consult, the application of public law principles and scope for judicial review, are sufficient to ensure providers have input into any proposed changes, without the need for additional oversight from a third party.

3. Getting better value for the NHS

Our original proposals

63. Our engagement document proposed:
    - 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
    - NHS services are removed from the scope of the Public Contracts Regulations 2015
    - NHS commissioners are instead subject to a new "best value" duty, supported by statutory guidance and
    - the power to set standing rules in primary legislation is amended to require inclusion of patient choice rights

64. The drive for greater integration of care set out in the NHS Long Term Plan is a continuation of the direction of travel established by the NHS Five Year Forward View (2014).

65. However, this will be harder to achieve while the NHS is subject to the current procurement and tendering rules which in the view of providers and commissioners can frustrate attempts to integrate care at scale, disrupt the development of stable collaborations, and involve protracted processes with wasteful legal and administration costs.

66. The NHS is currently subject to two sets of procurement rules – the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 (PPCCR) made under section 75 of the Health and Social Care Act 2012, and the Public Contracts Regulations 2015 (PCR), a set of public procurement rules which transposed the EU Directive on Public Procurement into UK law. Under the latter, contracts for health care services over a certain amount (currently £615,278 over the lifetime of the contract) need to be advertised and the applicable procurement procedures must be followed.

67. Removing the current procurement rules introduced by the PPCCR and the PCR and replacing them with a more flexible new NHS procurement regime would increase the ability of NHS commissioners to integrate services by providing them with more discretion in when to use procurement processes to arrange services. Our proposals are intended to ensure that tendering does not take place where it adds no value, by giving commissioners the discretion to choose either to award a contract directly to a provider, or to undertake a procurement process, in either case with the clear aim of ensuring good quality care, patient outcomes, and value for money when designing local healthcare services.

What we heard

68. Our proposals to free the NHS from the existing rigid procurement requirements (by repealing section 75 of the Health and Social Care Act 2012, revoking the PPCCR and removing NHS healthcare services from the scope of the PCR) attracted the strongest weight of support.

69. In response to our online survey, 76% of respondents strongly agreed or agreed with this proposal.

70. We also received a submission from the online campaigning organisation 38 Degrees who had sought the public's views on these proposals through an online survey. In total, 173,750 members of the public responded to the 38 Degrees survey. The scale of public engagement shows the appetite for reform to this legislation as it applies to the NHS.

71. 89% strongly agreed that the law should be changed "*so that contracts to run healthcare services no longer have to be put up for auction [seemingly referring to the current NHS procurement legislation]*." 97% of people said that local health services should typically be run by the NHS, not private companies.

72. The written responses to 38 Degrees from members of the public reflected concerns about waste and fragmented services with some responses drawing on the personal experience as patients, or NHS staff, to illustrate why they believe legislative reform is necessary.

73. Respondents to the 38 Degrees survey also gave their views on the circumstances in which private companies should be involved in NHS provision. 97% of people said that local health services should "typically" be run by the NHS, but there was support for use of private sector provision in certain circumstances, including:
    - As a short-term fix in an emergency situation or to bring down waiting times (44% agree)
    - When a private company provides a new service not available on the NHS (35%)
    - To keep a local service from closing down (34%)
    - When an NHS run service is not giving patients good care (23%)
    - When a private company is already successfully delivering care for patients (18%)
    - When a private company could provide a more cost-effective service (17%)
    - To make sure patients have a choice about who provides their care (10%)
    - 37% did not think use of independent sector providers should ever be considered

74. 38 Degrees concluded in their consolidated analysis of responses that *“while nobody underestimates the task of further legislative change to the NHS, the strength of feeling demonstrated in the survey proves that the public don’t just support these reforms, they expect them.”*

75. In addition, a separate petition run through “Keep Our NHS Public” attracted a further 8,543 e-mails. The standard response welcomed the abolition of section 75 of the Health and Social Care Act 2012.

76. In their report published on 24 June 2019, the Health and Social Care Select Committee supported the intent behind this proposal, noting *“The practice of procurement in parts of the NHS, particularly community and mental health services, has added complexities and costs to the system, with little added value for patients in return, and made it harder for services to integrate.”*

77. Overall, the level of support for our proposals was evident in most responses received.

Survey proposal	578 responses
2	To free up procurement rules including revoking section 75 of the Health and Social Care Act 2012 and giving NHS commissioners more freedom to determine when a procurement process is needed, subject to a new best value test?

78. Of those individuals and organisations who responded to this question via the online survey, 76% agreed or strongly agreed with the proposal, with only 15% disagreeing or strongly disagreeing. 9% of respondents were neutral towards the proposal. The vast majority of the respondents were members of the public and patients and 167 respondents provided free text to support their answers, in addition to the written responses received separately.

79. The responses generally supported the rationale for our proposals by providing examples which demonstrate that the current procurement regime is problematic, an inhibitor of integration, and can frustrate attempts to improve care delivery. Comments included:
    - *"At present, procurement processes tend to be burdensome and wasteful, unnecessarily disrupting the provision of high-quality local services and preventing effective planning over the longer term"* (NHS Providers)
    - *“There is strong evidence that the value of competition has been either limited or non-existent, while it is increasingly clear that the transaction costs of the market – such as the costs of tendering – are ludicrously high. Not only this, competition to provide services creates uncertainty, impacting on staff morale and staff retention.”* (North East London Save our NHS)
    - *“This is a deeply wasteful process and has a real cost to the NHS which would be better invested in service improvement”* (Shelford Group)

- *“Tendering services is a very large waste of time and money for all involved and severely impacts on patient / service user experience”* (Independent Provider Organisation)
- *"creating unnecessary tension in the system"* (Member of the Public)
- *"organisations often find themselves having to navigate a legal minefield simply to determine what is permissible"* (Kings Fund)

80. Many respondents are keen to maintain the option of running procurements as a tool for commissioners to use if they choose. For example:
    - *“There was also recognition [from CCGs] that procurement was a useful option to use as this could encourage innovative approaches and quality improvement from providers”* (NHS Clinical Commissioners)
    - *“The Trust recognises that there is a continued place for the use of competitive procurement”* (North Staffs Combined NHS Trust)

81. Some responses questioned how any changes to the NHS procurement regime might affect joint commissioning of services with local government:
    - *“The LGA supports the proposal to introduce a duty of best value for the NHS…With regard to joint commissioning arrangements between the NHS and local government, local councils are subject to the Public Procurement Regulations. We would be concerned if this difference created a barrier to existing or new joint commissioning arrangements, or of commissioning was inappropriately channelled through the NHS”* (Local Government Association)
    - *“In order to support integrated commissioning, it might be helpful to revise the application of the PCRs to some elements of local authority commissioning (e.g. public health, social care) where joint commissioning arrangements with local NHS partners are entered into”* (Bradford District and Craven CCG)

82. We agree that we do not want a new procurement regime to create new barriers to joint commissioning arrangements, and we currently believe that our policy intent would be best achieved if our new regime applied to any commissioning of NHS healthcare services.

83. The proposal for a new “Best Value Duty” was broadly supported in principle, but many respondents asked for further detail about how this would work. We set out how we are planning to answer this question in the following section.

84. The Health and Social Care Select Committee supported the principle of a “Best Value Duty” in their conclusions and recommended that the NHS Assembly should be the forum by which it is co-produced. It noted that *“the test should be underpinned by a broad definition of value, with the quality of care and health outcomes at its heart, but also aligned with conceptions of public and social value used by other public services.”*

85. Many respondents suggested that the new NHS procurement regime should be developed through further public engagement and that we should seek to learn from other similar concepts including the Best Value Duty on local authorities. We agree with this. The Health and Social Care Select Committee and several respondents also suggested that we do not refer to the new regime as a Best Value Duty, as this term is already in use, and has some potential for negative association with other similar duties. We agree with this suggestion.

86. Respondents were unclear what is meant by 'NHS providers' in the proposal, and whether we were deliberately limiting the new regime to arrangements made with statutory NHS bodies (i.e. NHS trusts and foundation trusts). Some respondents favoured the idea that new NHS procurement regime could be a means of prioritising NHS statutory providers over independent sector providers. However, others were concerned that if the proposals excluded non-statutory providers the consequences may be that patients suffer a lack of choice; that the important role played by the voluntary sector, social enterprises, and mutual organisations could be systematically diminished; that GPs and primary care networks, and community pharmacies may be excluded; and that monopolistic behaviour against the public interest may emerge.

87. For clarity, we intend that this new regime covers all arrangements, not just arrangements with NHS statutory providers. Some respondents asked whether the new NHS procurement regime would also apply in the purchasing of goods. Our recommendation is that the new arrangements would apply only to the commissioning of healthcare services.

88. Many helpful suggestions were submitted about what criteria should be included in the new NHS procurement regime. Some respondents included substantial detail based on their own experience and engagement, for which we are grateful, and which we will use as the new regime is developed. A common thread in responses was that the new regime should not solely be about finding the cheapest option, and that there are a range of other elements which are more important, in particular quality and safety of care; impact on patient outcomes; and social value and impact on the local economy.

89. Alongside comments about the content of the new regime, many respondents emphasised the importance of ensuring it is followed properly by commissioners. Many emphasised that we must make sure it is as simple as it can be, and that there is clarity about how and when it should be used so as to avoid creating more uncertainty, risk-averse decision-making or bureaucracy.

90. Respondents said the new NHS procurement regime needs to be transparent, objective, and subject to appropriate oversight and scrutiny, with the possibility of reviewing or challenge decisions made by commissioners.

91. Our commitment to preserve and strengthen patient choice was also subject to comment, with respondents agreeing with the need to preserve patient choice, but also some recognition that the nature and role of patient choice in the system is evolving beyond a simplistic ‘choice between different providers’ to more granular choices about ways of accessing care, available treatment options and shared decision making: *“Patient choice rights should be enshrined and not eroded. At the moment, they have statutory underpinning and any regulatory or legislative shift should strengthen patient choice and control rather than weaken it.’* (Member of the public)

92. The Health and Social Care Select Committee supported the commitment to preserve and strengthen patient choice. The evidence they took during the course of their inquiry suggested that *“practical considerations such as geography have a greater influence on the exercise of patient choice than legislation, and that what most patients want is good quality care close to their home.”* And went on to conclude *“Using patient choice as a lever to improve quality may help for some services, particularly planned or elective care, but as an organising principle, we believe that encouraging collaboration between providers is a much better way to provide good-quality care for patients, especially those with multiple long-term conditions.”*

93. The Committee also concluded that in developing the proposals the Department, NHS England and NHS Improvement should *“ensure that they do not have unintended consequences that negatively impact on the ability of patients to exercise their right to choose between providers.”* They also noted that having a right to choice relies on that right being enforceable and recommended that an appeal mechanism is preserved, within an existing independent body, for patients who believe they have been denied choice.

94. These comments demonstrate a broad consensus. We outline how patient choice would be protected under Recommendation 7 below.

Recommendation 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

Recommendation 5: The commissioning of NHS healthcare services is removed from the scope of the Public Contracts Regulations 2015

Recommendation 6: Introduce a new NHS procurement regime, supported by statutory guidance

95. Overall, responses to the engagement exercise support these proposals. We therefore recommend that legislation is changed (as set out below) give effect to the proposals.

96. We recommend that section 75 of the Health and Social Care Act 2012 is repealed and we recommend that new provisions are made in legislation and statutory guidance which:

- establish a new NHS procurement regime under which commissioners of NHS healthcare services must act in the best interests of patients, taxpayers, and the local population when making decisions about arranging healthcare services. They would also have to act in accord with criteria set out in statutory guidance.
- permit NHS commissioners to make such arrangements at their discretion (i.e. without having to undertake a full tendering exercise first unless it would be in the interests of patients, taxpayers and the local population), subject to adherence to related statutory guidance.
- establishes a power to issue statutory guidance to which NHS commissioners must have regard when making such arrangements with providers.
- removes the commissioning of NHS healthcare services from the scope of the Public Contracts Regulations 2015. The extent to which this is achievable is contingent on other legislative proposals, as well as broader issues relating to EU law and the UK's future relationship with the EU.
- these changes should apply to commissioners when making decisions about healthcare services only. It is not intended that other NHS procurements (such as procurement of pharmaceuticals) are taken out of the scope of PCR.

97. Our recommendation that section 75 of the 2012 Act is repealed would also involve revocation of the PPCCR. Specific provisions relating to patient choice are detailed under amendments to legislation as part of recommendation 7.

98. We recommend that the requirement in regulation 6 of the PPCCR for commissioners to properly manage conflicts of interest when making commissioning decisions is retained elsewhere in legislation.

New NHS procurement regime (Statutory Guidance)

99. The most common response to our engagement was a request for greater clarity about how the "Best Value Duty" or new NHS procurement regime is intended to operate.

100. We have concluded that we should set out draft proposals and undertake a separate dedicated public consultation, at the same time as the Bill is published. This will include a process of broad engagement.

101. We also heard that we need to distinguish between what are the rules for when procurement does or not occur are different from the criteria that should apply in awarding contracts. For example, we agree with respondents that some

services should never normally be subject to procurement either because the NHS is the only credible provider (e.g. Type 1 A&E) or because providers are contracted at zero guaranteed value through an accreditation process (e.g. for elective choice) and where adding an extra procurement process on top of an accreditation process is needless bureaucracy.

102. We also agree that commissioners should always, as now, continue to have the ultimate right to choose to use procurement where they consider this in the best interests of their population, without fear of unnecessary challenge. Where commissioners do so, they should ensure they do so in a way which is compliant with relevant guidance and principles on the use of public funds, such as Treasury Guidance (Managing Public Money), which would be reflected in the new NHS regime.

103. We intend the new regime to apply when making arrangements with all providers of NHS services, rather than just NHS statutory providers. For clarity, the new regime is not intended to apply to decisions about buying goods – our recommendation is that it would relate only to arranging healthcare services.

104. We also agree that the duties would need to be compatible with commissioners' existing duties including public engagement and consultation, management of conflicts of interest, equality, reducing inequality and others. We too agree that appropriate scrutiny and oversight mechanisms are needed. There are important roles here for NHS England through its formal accountability relationship with CCGs; for internal audit in ensuring that CCGs have acted in the interests of patients, taxpayers and the local population in accordance with the new regime's criteria; and for health and wellbeing boards who should be engaged in deliberations about key service developments.

105. As to the criteria for awarding contracts, we heard that all aspects of quality (including safety, effectiveness, and experience) were important, as well as patient choice and improving access, tackling inequalities, promoting integration of care, ensuring sustainability of services, value cost and affordability, generating or maintaining social value, and promoting innovation.

106. In line with engagement feedback, we have opted not to give the new regime the name "Best Value Duty". We heard significant concerns that this title implies that the cost of services would be the predominant consideration in healthcare investment decisions. This is clearly not our intention. We refer therefore to the "new NHS procurement regime" pending better suggestions.

Recommendation 7: Amend the power to set standing rules in primary legislation to ensure that patient choice rights are protected

107. As part of the wider package of changes to procurement policy we have proposed to revoke the PPCCR made under section 75 of the 2012 Act and repeal the powers in primary legislation under which they are made. As noted in sections above, respondents were keen that we should ensure the wider procurement proposals do not diminish patient choice in any way. The paragraphs below explain how we propose to ensure appropriate patient choice.

108. The PPCCR currently contain important protections around patient choice, which complement and further strengthen other provisions around choice set out in other parts of legislation, in guidance and in NHS commissioning contracts.

109. We propose that the specific choice elements of the PPCCRs are maintained following the revocation of the PPCCR. We propose this is achieved by amending the power in primary legislation to set standing rules to ensure that additional provision is made in relation to protecting and promoting the right to patient choice; and then amending the standing rules themselves to include the provisions on choice currently in the PPCCR.

110. Maintaining the choice elements of the PPCCR in the Standing Rules would mean:
    - that patients continue to have a legal right to choice for particular services in the same way that they do at the moment
    - that commissioners are still required to offer and facilitate choice to patients, including where appropriate through the use of Any Qualified Provider (AQP) arrangements
    - that NHS England and NHS Improvement keep Monitor's powers of investigation and enforcement, so we can investigate breaches of patient choice requirements and take action against commissioners with respect to breaches of requirements in relation to the arrangements they make to ensure patient choice

111. We propose that the power to make standing rules (section 6E of the Act) is amended so that:
    - it is clear that the Secretary of State can set requirements for the purpose of protecting and promoting choice, not just requirements as to the arrangements they must make to enable patients to make choices (see section 6E(2)(c) of the 2012 Act) and
    - it includes specific power to make provision for NHS England to secure compliance with the requirements on CCGs relating to patient choice

112. In addition, we propose that legislation is amended so that the standing rules regulations ***must*** **include** provisions for patient choice, not simply *may* include (as currently set out in sections 6E and 75 of the 2012 Act). We propose that the standing rules are amended to include the patient choice provisions that would be revoked on repeal of section 75. Specifically, we propose replicating the following provisions:

- the requirement to treat providers in a non-discriminatory way
- the requirement to consider appropriate means of improving services, including through allowing patients a choice of provider
- the requirement for commissioners to establish and apply transparent, proportionate and non-discriminatory criteria to determine which providers qualify to be included on a list from which a patient is offered a choice of provider in respect of first outpatient appointment with a consultant or a member of a consultant's team
- the prohibition on NHS England placing certain restrictions on the ability of a patient to choose their primary health care provider
- the requirement to put in place arrangements to ensure that patients are offered a choice of alternative providers in certain circumstances where they will not receive treatment within maximum waiting times
- the power to investigate and take action in relation to any complaint in relation to patient choice, including complaints relating to a patient's right to choose their GP practice or the practitioner within the practice, choose the provider/team for their first outpatient appointment and choose an alternative provider where waiting times will be breached and requirements on commissioners to put in place arrangements to publicise and promote certain information about choice

113. We will also seek to clarify the current provisions around the AQP regime (specifically reconciling the current provisions in the standing rules (regulation 39) with regulation 7 of the PPCCRs).

4. Increasing the flexibility of national NHS payment systems

Our original proposals

114. Our engagement document invited views on proposals that would:

- allow national prices to be set as a formula rather than a fixed value, so that the price payable can reflect local factors (but is not a move away from national prices to local prices)
- provide a power for national prices to be applied only in specified circumstances, for example allowing national prices for acute care to cover 'out of area' treatments but enabling local commissioners and providers to agree appropriate payment arrangements for services that patients receive from their main local hospital in accordance with tariff rules
- allow adjustments to provisions within the tariff to be made (subject to consultation) within a tariff period, for example to reflect a new treatment, rather than having to consult on a new tariff in its entirety for even a minor proposed change
- remove the power for providers to apply to NHS Improvement to make local modifications to tariff prices once Integrated Care Systems (ICS) are fully developed
- allow the National Tariff to include prices for 'section 7A' public health services where commissioned by the NHS
- remove the need for NHS Improvement to refer contested National Tariff provisions to the Competition and Markets Authority (CMA). (See section 2)

115. The NHS Long Term Plan makes clear that reforms to the payment system will move funding away from activity-based payments and ensure a majority of funding is population-based. This will make it easier to redesign care across providers, support the move to preventative and anticipatory care models, and reduce transaction costs.

116. The National Tariff Payment System (NTPS) under Chapter 4 of Part 3 of the 2012 Act allows flexibility to support new ways of delivering care. Rules on locally determined prices allow providers and commissioners to set appropriate local prices and payment approaches, provided they are in the best interest of patients, promote transparency and result from the engagement of commissioners and providers.

117. Nonetheless, there are still areas where there could be further flexibility and areas where the legal framework for setting prices could be amended to better facilitate integration, for example, to move to a population-based payment that requires elements to be locally agreed within a national, rules-based system.

What we heard

Survey proposal	579 responses
3	*Do you agree with our proposals to increase the flexibility of the national NHS payments system?*

118. Of those individuals and organisations who responded to this question via the online survey, 70.4% agreed or strongly agreed with the proposal, with only 10.4% disagreeing or strongly disagreeing. 19.2% of respondents were neutral towards the proposal.

119. In addition to the 579 online survey responses to this question, of the 82 written responses, 47 appeared supportive of the proposals with three clearly opposed (one of which was an independent provider) and the remainder not expressing a clear view.

120. The Health and Social Care Select Committee also supported the intention to provide greater local flexibility over the use of the national tariff system recognising that *"Providing more flexibility will help local providers and commissioners to remove perverse incentives, especially in managing patients with multiple long-term conditions."*

121. However, the Committee also recognised that the tariff helps ensure that providers compete on the quality, rather than the price, of the care they deliver and consequently sought reassurance on how the Department, NHS England and NHS Improvement plan to avoid and/or mitigate concerns that these changes could result in price competition.

122. The objective of the proposed changes is to enable more flexibility in how we set tariff prices and rules to support the implementation of new payment models, such as blended payment for emergency care, and multi-year tariff setting. We are not proposing changes to the current mandatory rules[4] which apply where there is agreement between providers and commissioners to move away from national prices. These rules state that where prices are determined locally, they must be demonstrably in the best interests of patients today and in the future.

123. Some respondents who supported the proposals overall did however add caveats and/or additional suggestions, such as:

[4] See Section 6.1 of the 2019/20 National Tariff Payment System publication at https://improvement.nhs.uk/resources/national-tariff/

- *“Formula makes sense in principle, however detail of what the formula is and how this would be policed to prevent gaming for increasing revenues needs to be spelt out”* (Member of the public)
- *“There must be a mechanism for arbitration and dispute resolution to prevent local flexibility leading to market failure or unwarranted reductions in choice, accessibility and / or quality.”* (Specsavers group)

124. The highest proportion of identifiable ‘disagree / strongly disagree’ responses came from patients and members of the public. Many of these responses featured comments opposing privatisation of NHS services rather than comments about the specifics of the proposals in relation to the payment system.

125. Specific issues raised included:
    - *“the current system of national uniform pricing is a vital safeguard against allowing competition to be based on price, rather than quality”* (Spire Healthcare)
    - *“Strongly disagree with setting national prices as a formula - this is already a formula and MFF accounts for national differences. This would encourage tariff ‘cherry picking’ and make negotiations more complex. It’s also worth noting that national tariff was introduced so that providers could compete on quality, but not cost. The opportunity to renegotiate tariff locally risks making cost the main factor.”* (Sheffield CCG)
    - *“Removing the national oversight and regulation could create significant variance in local behaviours which may not always be in the patient's benefit”* (Northamptonshire Healthcare NHS Foundation Trust)

126. Given the overall general level of support, we do not intend to make any substantive changes to our proposals in response to the engagement feedback received. We will continue to work with respondents to address any further requests for clarification and/or further detail on issues such as:
    - the nature of the proposed price-setting ‘formula’ and how this is not a move to introduce price competition
    - tariff flexibilities already available, to address concerns about the proposed removal of local modification applications

Recommendation 8: Where NHS England and NHS Improvement specifies a service in the National Tariff, then the national price set for that service may be either a fixed amount or a price described as a formula

127. If specifying a price as a formula, NHS England and NHS Improvement would have to specify the individual elements of that formula.

128. This specific proposal has been misunderstood as representing an abandonment of national prices in favour of locally-determined prices. The aim is to build greater flexibility into the national tariff to enable it to better support

system change designed to deliver better quality and more sustainable patient care. For example, it would better support implementation of a 'blended payment' approach (mix of fixed and variable elements) by enabling payments to be based on national prices and locally agreed activity plans. It would also support multi-year tariffs by enabling future tariffs to be set as current price multiplied by inflation, for example measured as GDP deflator on X date and pay award for Y year.

129. We propose that the legislation would ensure that the variable inputs provided for by a national formula may refer to matters determined and published separately by NHS England and NHS Improvement or a third party (e.g. the retail price index) or determined locally (e.g. a forecast of activity for the relevant service for the coming year as agreed between the commissioner and a provider of that service).

130. We propose that NHS England and NHS Improvement would determine whether any particular price is a fixed amount or a formula – and could provide for all prices to be a fixed amount or for all prices to be a formula. It would also be able to apply different formulae to different services.

Recommendation 9: NHS England and NHS Improvement could amend one or more provisions of the national tariff during the period which it has effect

131. As our engagement document set out, NHS England and NHS Improvement are perversely unable to update prices in-year to reflect for example changes in the cost of medicines included in tariffs. We should therefore be able to amend a national tariff at any point during its period of effect (and be able to make amendments any number of times). NHS England and NHS Improvement would be required to consult (for a period of 28 days, as with consultation on a full tariff) with those affected by a proposed change.

132. The power to amend would be subject to the limitation that it should not apply where the change is so significant as to require a new national tariff and full consultation exercise. NHS England and NHS Improvement would have to determine whether a change was so significant by reference to certain factors:
   - the proportion of relevant providers or commissioners affected by the change
   - the likely extent of any impact on those affected
   - are any relevant provider or commissioner, or group of providers or commissioners, likely to be disproportionately affected by the change (when compared to other commissioners or providers affected)?
   - what would be the amount of any increase or decrease to prices (if any) as consequence of the amendment?

Recommendation 10: Remove the requirement for providers to apply to NHS Improvement for local modifications to tariff prices

133. We expect that this would come into effect once ICSs are fully developed as any modifications to tariff prices should be agreed within the ICS and providers and commissioners would still be able to agree local modifications to tariff prices. Significant flexibilities already exist for providers and commissioners to agree local variations to tariff prices or structures where it is in the best interests of patients.

134. Applications for local modifications have rarely been used and, where they have, our experience has been that they are as a result of financial disputes between providers and commissioners. The process is not conducive to integrated working and, once ICSs are fully developed, there should be no reason why providers need to apply to NHS Improvement for a local modification of national prices rather than reach local agreement. The relevant provisions should therefore be repealed.

Recommendation 11: NHS England and NHS Improvement should be able to include provisions in the National Tariff on pricing of public health services under section 7A agreements with NHS England

135. This new provision would be required so that national tariff and the regime for NHS pricing could be extended to cover public health services commissioned by NHS England or CCGs under arrangements with the Secretary of State under section 7A of the National Health Service Act 2006, as well as NHS healthcare services. The purpose of this change is to enable better integration of public health services with local commissioned services (e.g. childhood immunisation and maternity services). It was strongly supported.

5. Integrated service provision

Our original proposals

136. The proposal set out in our engagement document was to remove the legal uncertainty that exists around the Secretary of State's power to create new NHS trusts and to define the use of that power around the specific purpose of integrating and delivering health and social care services.

137. The primary objective of this proposal was to address a barrier to implementation of Integrated Care Provider (ICP) models. Commissioners may determine, following discussions at Integrated Care System (ICS) level, that an ICP model is right for their population, but there may not exist a suitable and fit for purpose statutory NHS provider to perform the role of the ICP in that area. The current legislative framework restricts the ability of the NHS to resolve this - a new NHS foundation trust cannot be created from scratch and the 2012 Act did not envisage the creation of any new NHS trusts (it provided for the abolition of NHS trusts, although those provisions have not been brought into force).

138. We want to maintain the current legislation for NHS trusts, repeal the provisions for their abolition and remove any uncertainty there is as to the power of the Secretary of State to create a new NHS trust to deliver an ICP contract where local commissioners (with support from ICS members and other local stakeholders) believe that would be the best option.

What we heard

Survey proposal	582 responses
4	Enable the Secretary of State to set up new NHS trusts to provide integrated care.

139. Of those individuals and organisations who responded to this proposal via the online survey, 74.8% agreed or strongly agreed with the proposal, with only 12.8% disagreeing or strongly disagreeing. 12.4% of respondents were neutral towards the proposal. Responses were received from a wide spectrum generally supportive of the proposal as an option for local systems to enable integration.

140. The Health and Social Care Select Committee supported the proposal noting that *"This change to the legislation will extend the ways in which local commissioners can integrate health and social care."* However, the Committee went on to say: *"Our view is that this power must not be used by the Secretary*

of State to impose a form of integration on local health and care services or as threat to incentivise organisations to collaborate."

141. Many welcomed this as an option for systems and local areas wishing to use a contractual route to integrate services under the ICP Contract:
    - *"We welcome this proposal as it could provide a clear delivery model for the provision of integrated care."* (Sussex and East Surry Clinical Commissioning Groups)
    - *"We understand that the proposal to enable the Secretary of State to be able to set up new integrated care trusts could create beneficial flexibility within the system and be key for the drive for increased collaboration and integration."* (Herts West Essex STP)
    - Some noted the benefits of a statutory provider holding the ICP contract[5]: "*UNISON also strongly supports the use of new NHS trusts as a way of creating a mechanism for any future Integrated Care Provider (ICP) contracts to be held by public sector bodies."* (UNISON)

142. Key benefits of the proposal that were emphasised in the responses included the opportunity to address current service fragmentation by giving a lead provider greater responsibility for coordinating care provision. Many pointed out the current frustrations that patients experience where services are not delivered in a joined-up way: *"There are currently too many organisational boundaries which create ""hand-offs"", fragmentation and duplication; and may also limit integration."* (Marie Curie).

143. Some responses did acknowledge, however, the limitations of this proposal alone in addressing the barriers to better service integration. Respondents including some think tanks, charities and providers caveated their support by pointing out that organisational change alone does not deliver integrated care and stressed the importance of trust, culture, relationships and leadership as key enablers: *"Given the fragmentation of current commissioner and provider roles within the NHS, the appeal of such an approach is clear. However, it should be noted that there is overwhelming evidence that organisational change alone does not deliver integrated care because it does not address the critical importance of the 'soft' issues of trust, relationships and ways of working*." (The Association for Adult Social Services). We strongly agree with this.

144. Other responses noted that this presents a contractual solution which is important but not the only way of achieving better service integration: *"this could in theory be a helpful option for areas wishing to use a contractual route to integrate services under the integrated care provider (ICP) contract (if and*

[5] These emerged as a strong theme in the consultation on the ICP contract – see https://www.engage.england.nhs.uk/consultation/proposed-contracting-arrangements-for-icps/user_uploads/icp-consultation-response.pdf

when this is made available) by creating a suitable, publicly accountable NHS organisational form to hold the contract” (The Kings Fund).

145. Some responses wanted greater detail and clarity on the proposal including how this would work in practice: *“we see its potential to create some helpful flexibility in the system. However, we are also cautious about its detailed framing and implementation*” (NHS Providers).

146. Other areas where further clarification was sought include:
   - the consultation requirements
   - how the application process would take account of support and any objections
   - the role of NHS England and NHS Improvement in the process
   - Compliance with good governance rules
   - the patient, clinical and value for money tests that would be applied

147. Some responses also raised a number of potential concerns with how the proposal might work in practice. These can be grouped into four broad themes:
   a. Ensuring the appropriate use of the power to create new NHS trusts and putting in place suitable safeguards and protections
   b. Ensuring local involvement and engagement in identifying this as the preferred delivery vehicle option and in the governance arrangements of the new NHS trust
   c. The ability of the ICP contract and new NHS trust creation to address barriers to health and social care integration and the importance of including local authorities as part of the solution
   d. The implications for existing statutory NHS providers and the impact of organisational change

a. <u>Ensuring the appropriate use of the power to create new NHS trusts and putting in place suitable safeguards and protections</u>

148. Some responses raised concerns about how the power to create new NHS trusts might be used particularly by Government and national bodies and whether this would be at the expense of local discretion.

149. The Health and Social Care Select Committee, supportive of the proposal, recommended that *“the Secretary of State must not be allowed to exercise this power without a request from the local clinical commissioning group(s). [And] We recommend that a request to the Secretary of State must follow a robust assessment and public consultation to ensure the creation of a new NHS trust is in the best interests of patients and the local population and represents an efficient use of public money.”*

150. The Health Scrutiny Committee for Lincolnshire County Council commented: *“that the Secretary of State should be able to set up new NHS Trusts, as the*

Committee understands that these would operate under a single contract to further aid integration. However, the Committee believes that local health and care systems should be empowered to make decisions on the delivery of services, with national and regional or entities only becoming involved where absolutely necessary."

151. NHS Providers also said *"we would be concerned that the following are properly taken into account:…[That] The creation of a new trust is locally driven and not imposed by the centre. At worst, there is the danger that this proposal gives a secretary of state unilateral powers to reconfigure healthcare systems."*

152. Other responses wanted clarity over the checks and balances that would need to be put in place: *"What arrangements, if any, will be established to provide assurance that the decision to create a new trust is the most appropriate option?"* (Health Foundation)

153. There was support for new NHS trusts to only be established where local commissioners wish to bring services together under a single contract, where there has been appropriate local engagement and where it is necessary to establish a new organisational vehicle for these purposes. It was suggested that a clear business case demonstrating clear benefits to patients and service quality would be required: *"it is important that a compelling case for the use of such powers is made as there may be a risk that creating new organisations fragments leadership across systems rather than promoting collaboration and integration."* (Wolverhampton CCG)

154. The Federation of Ophthalmic and Dispensing Opticians also remarked: *"If there were sufficient checks and balances in place, then yes, it is sensible for the Secretary of State have powers to establish new NHS trusts to deliver integrated care services across a given area, provided the NHS Constitution is adhered to and patients, not institutions, are put at the heart of the NHS."*

155. To address these concerns we would intend to define that the power could only be exercised either:
    - where the trust is to be established for the purpose of securing the provision of integrated care for the population of a particular area or a particular CCG or group of CCGs
    - or only as may be specified in regulations

b. *Ensuring local involvement and engagement in identifying this as the preferred delivery vehicle option and in the governance arrangements of the new NHS trust*

156. Some responses emphasised the importance of the considerable engagement that would be required locally before opting for this as the preferred delivery vehicle: *"We would like to see more detail as to how the public and clinicians*

will be engaged on such a proposal, and how this local engagement will be formalised prior to the creation of such a trust." (The British Medical Association).

157. This sentiment was expressed by local partners who would need to be an essential part of any lead provider arrangement in the delivery of integrated care: *"The creation of the new vehicle of Integrated Care Trusts would be welcome if it enabled a greater degree of GP and primary care leadership."* (Royal College of GPs).

158. For the establishment of the new integrated care NHS trusts, there would be an application and approvals process set out in regulations. It is envisaged that the procedure would include requirements as to the following:
    - the applicant – this would be commissioners wishing to award the ICP contract
    - engagement undertaken and local support
    - the rationale – this would set out the strategic business case around the award of an ICP contract and the necessity for/desirability of a new NHS trust to deliver it
    - the proposed governance composition for the proposed NHS trust, which should reflect the clinical expertise/specialties/delivery partners required to deliver the relevant ICP contract service scope, and local authority and patient/community representation

159. We would also set out specific requirements in regulations as to who should be consulted before a new NHS trust is to be established. This would include:
    - relevant local NHS providers
    - relevant local authorities and their local health and wellbeing boards
    - relevant ICS partnership board (contingent on relevant legislative proposal)
    - local Healthwatch
    - patients and the public
    - key stakeholders and delivery partners including local NHS providers and PCN configurations
    - NHS England and NHS Improvement

c. *The ability of the ICP contract and new NHS trust creation to address barriers to health and social care integration and the importance of including local authorities as part of the solution*

160. Some responses raised the question of local authority involvement and whilst they often recognised that the creation of new NHS trusts did not have a direct impact on local authorities, clarity was sought as to their role in such arrangements: *"An external, but essential, factor in the likely success of integrated care will depend on the role of local government. Partnership between the NHS and local authorities to deliver health and social care is fundamental to the Long Term Plan."* (ICSA: The Governance Institute)

161. The Local Government Association (LGA) in supporting the power for Secretary of State, made clear that: *"in coming to a decision, the Secretary of State will need to seek the views of local communities and councils on whether the creation of a new trust will lead to better health and wellbeing outcomes, better care and support services and better use of public resources. Furthermore, there will need to be clear assurances that new trusts will be locally accountable for their outcomes, services and use of resources."*

162. Some responses highlighted the importance of health and social care service integration. They were keen to emphasise the importance of any new local delivery arrangements integrating closely with social care services: *"People with neurological conditions often need to access services across acute and elective care, community-based support and primary care, mental health, and social care."* (Neurological Alliance)

163. Many of these themes were also raised and addressed as part of the response to the ICP contract consultation. That consultation received general questions about how adequately the then current version of the ICP contract provides for integration of local authority services with healthcare services. They also expressed concern about potential barriers to a local authority itself holding an ICP Contract, and we heard some wider views about potential obstacles to local authority participation in an ICP model. The ICP contract has been amended to seek to overcome those barriers insofar as possible within the statutory framework, and we have undertaken to continue to engage closely with local authority representatives as part of further ICP contract development.

d. The implications for existing statutory NHS providers and impact of organisational change

164. A common theme to emerge amongst existing statutory providers was the implications of this proposal for them and the existing provider landscape. Some pointed to the sustainability of the local system and how it might impact existing NHS providers and the stability of local systems. Some of those responses suggested that to help mitigate for this, consideration should be given to existing delivery vehicle options in the first instance: *"The ability for new NHS Trusts to be established which would cover the span of services included within the ICP Contract (where local Commissioners have decided this is the optimal way forward) is a positive step and is welcomed by the Trust…… care should be taken that, in such instances, the focus is rightly retained on clinical and professional integration for patient benefit. ... Where the proposals to be taken forward in their current form, the Trust would hope that such changes would be positioned as a discretionary option supported by appropriate assurance and consultation programmes and that equal weight would be given to promoting creative use of existing options."* (North Staffs combined NHS Trust)

165. There were also questions around the value of new NHS trust creation pointing to the availability of existing NHS providers: *" A number of Foundation Trusts are already integrating the provision of specialist, secondary, community and social care services."* (Shelford Group)

166. A number of responses pointed out the potential for the creation of new NHS trusts to take up considerable local effort and resource: *"The Trust supports any measure that will allow NHS bodies to work in an integrated manner where it provides patient focused care. However, establishing new organisations is resource heavy and creates uncertainty and the establishment of a new organisation will not remove all of the barriers to integration."* (Dudley and Walsall Mental Health Partnership NHS Trust commented)

167. However, it was also pointed out that there can be challenges in identifying a suitable existing statutory provider. Dudley CCG who are exploring use of the ICP contract explained that: *"Powers to the minister could overcome the difficulties commissioners can face in identifying an existing organisation that could take on responsibility for an ICP contract".*

168. The NHS Confederation also demonstrated support if local circumstances necessitate: *"we contend that they should only be established where it is clear that this is the most effective way of delivering high quality services at best value. Any decision must be in the interests of local people and the service as a whole."*

169. We agree that in some cases it will make sense to award an ICP contract to an existing statutory provider. Providing the option of the creation of a new NHS trust, on the application and with the support of local stakeholders, does not preclude an existing statutory provider being awarded an ICP contract should it satisfy locally-determined selection criteria.

170. As part of their report, the Health and Social Care Select Committee made broader recommendations in relation to the ICP Contract. The Committee strongly recommended that *"legislation should rule out the option of non-statutory providers holding an ICP contract. Doing so would allay fears that ICP contracts provide a vehicle for extending the scope of privatisation in the English NHS."* The Committee also strongly urged that *"ICP contracts should be piloted only in a small number of local areas and subject to careful evaluation and that they should not be not held by non-statutory providers."*

171. The Allied Health Professions also suggested "*the legislative proposals should be extended to give a statutory basis to NHS E&I's "expectation" as articulated in the Long Term Plan, that only public/NHS bodies can be Lead Integrated Care Providers (Long Term Plan para 1.54). Such a provision would negate*

one of the strongest points of public concern in an otherwise positive integration agenda."

Recommendation 12 - Secretary of State should continue to have the power to establish NHS trusts (for prescribed purposes) and NHS trusts should continue to be part of the NHS legislative framework.

172. We propose revoking the provisions in the Health and Social Care Act 2012 for the abolition of NHS trusts and related repeals and amendments. This would confirm the retention of the NHS trust model and the Secretary of State would be able to establish new NHS trusts for the specific purpose of delivering the ICP contract (or similar arrangement), without the potential uncertainty if the provisions for abolition remain in place.

173. In accordance with the Health and Social Care Select Committee's recommendation, non-statutory providers would not be able to hold an ICP contract under this provision. This would be subject to our recommendation to remove NHS commissioning from the scope of the Public Contracts Regulations 2015, as set out earlier in this document.

174. In addition to maintaining the existing provisions for the establishment and operation of NHS trusts, we propose that primary legislation would include provision for regulations that would govern how the power to establish new NHS trusts is to be exercised, including the application process.

175. Additional non-statutory guidance may be needed to explain the policy intention around the use of the power to those ICSs considering the ICP model at place level.

6. Managing resources efficiently

Our original proposals

176. Our engagement document proposed to:
    - give targeted powers to NHS Improvement to direct mergers or acquisitions involving NHS foundation trusts in specific circumstances where there are clear patient benefits
    - give NHS Improvement powers to set annual capital spending limits for NHS foundation trusts

177. The proposal in respect of NHS foundation trust (FT) mergers was based on the rationale that, whilst mergers will not be appropriate everywhere, in some cases they can help ensure that services across different sites can be delivered in a more sustainable way clinically and financially. We want local provider organisations and their partners to agree where mergers are needed and how to take them forward. However, such developments can sometimes be frustrated by the reluctance of a single local trust to agree to a merger. In such circumstances, where a merger would bring clear benefits to patients, we proposed that NHS Improvement should have the power to direct an FT to enter into joint working relationships, including merging with an NHS trust or another FT; or be acquired by another NHS FT.

178. In relation to capital spending limits, the NHS Long Term Plan set out the urgent need to invest in the buildings and facilities of the NHS, to meet the demands of a modern health service. This requires, among other changes, increased overall capital investment, as well as a more coordinated and collaborative approach to planning capital investment. Local health systems, particularly the emerging integrated care systems, are playing a growing role in coordinating decisions by local health bodies on priorities for capital investment and how to make more effective and efficient use of their physical assets in support of integrated care.

179. One of the current barriers to developing this more collective approach is that, whilst Parliament approves an annual financial envelope for capital expenditure across the Department of Health and Social Care (the Department) and the NHS, there are no mechanisms to set capital spending limits for NHS foundation trusts. This leads to situations where, because of uncertainty or unpredictability associated with capital spending by foundation trusts, it becomes necessary to constrain or delay capital spending by non-foundation trusts that may be more urgent or address higher-priority needs. It increases the risk that the Department and the NHS collectively could exceed the limits prescribed by Parliament – and it limits the extent to which NHS Improvement can work with local health systems to help improve planning of capital spending for the benefit of patients.

What we heard

Survey proposal	581 responses
5a	Give NHS England and NHS Improvement targeted powers to direct mergers involving NHS foundation trusts, in specific circumstances only, where there are clear patient benefits

180. Of those individuals and organisations who responded to this question via the online survey, 70.3% agreed or strongly agreed with the proposal, with only 12.6% disagreeing or strongly disagreeing. 17.2% of respondents were neutral towards the proposal.

181. Whilst the survey responses indicate strong support for the proposed power to direct mergers, the separate written responses and discussion at national roundtables raised a number of issues. A number of respondents expressed the concern that the power might be misused or be too prescriptive. The NHS told us of their concerns that directed mergers would impede delivery of patient benefits. Trusts told us:
   - *Given that this would only be enacted for a Trust that objects to the considerations it is important that any process put in place is very clear about how the objections of a separate statutory entity would be taken into account and what the test of patient benefits would be before the independence of an FT was overridden.* (The Royal Marsden NHS FT*)*
   - *Delivery of the full benefits of merger or acquisition and integration of services could be at risk without cooperation between providers and staff in situations where they are directed into mergers or acquisitions and this may also require changes to the existing legislation and framework for transactions depending on who would be responsible for mergers and acquisitions in situations where these are implemented without approval of NHs foundation trust boards of directors.* (Royal Bournemouth and Christchurch NHS FT)
   - *The ability to direct mergers should be dependent on there being a clearly defined criteria and process, with appropriate governance and safeguards to ensure that there is accountability to deliver value for money for the NHS. Whilst pace and streamlined process is desirable, it cannot be valued at the expense of suitable due diligence on benefits realisation.* (North Middlesex University Hospital Trust)

182. Frimley Health and Care Integrated Care System clarified that while they understand the rationale for the proposal, they could only support a proposal for a direction if there was wider local system support. They told us that they: *"Support the idea that mergers in situations where clear patient interests aren't*

being acknowledged by all parties should be able to be directed, but only with the support and agreement of local system leadership, particularly in mature ICS areas."

183. The Greater Manchester Health and Social Care Partnership acknowledged: *"Whilst we can understand the rationale for the suggested change, this proposal does not have system support. Even if this facility is viewed as exceptional, it would signal the failure of the ICS to develop the right relationships to facilitate the change."* While Central North West London FT told us: *"Decisions on merger should be left to the maturing ICS's. To put in an alternative mechanism will undermine a central tenet of their ability to make decisions with the local system, at this early stage in their development. NHSE/I dispute resolution should be available as a fail safe."*

184. The Health and Social Care Select Committee, both in relation to mergers and proposals on capital limits (below), were clear that local systems should be *"empowered to decide the most appropriate way to manage NHS resources. This includes being encouraged to resolve disputes between local partners about the best way to manage resources, including capital resources, within the system."* They recognised that *"there may be circumstances in which national intervention is necessary to ensure one local partner is not, unreasonably, frustrating system-wide efforts"*. The Committee did not support proposals as presented in the engagement document. If taken forward the Committee would expect there to be specified limited circumstances in which these powers could be exercised. They recommended such powers should: *"focus on a) removing barriers to integrated care and b) empowering and encouraging local systems to resolve disputes over the configuration of services and the management of resources, including capital resources, themselves."*

185. A key theme raised by NHS Providers is that successful local collaboration in the delivery of care depends on goodwill, strong relationships and shared aims. They questioned how a mandated merger would work. In their view, it would: *"Fundamentally cut across the autonomy of a board and so leave its officers accountable for a decision they have note made"; "Go directly against the grain of the policy intent, wherein integration is locally driven"; and "Likely fail to realise the intended patient and/or financial benefits as any case made against the merger would still exist".*

186. NHS Providers recommended an alternative approach: *"NHS Improvement should facilitate dialogue between local bodies and with the centre to understand the source of concerns and give appropriate assurances… Where the case in favour of a merger is undeniable and its risks manageable, such that trust duties are being breached in refusing to countenance it, NHSI should use its existing proportionate regulatory powers to address that refusal. This includes:*
    - *exercising their normal system oversight relationship with trusts.*

- *NHSI seeking to use its regulatory powers of intervention, for example, questioning whether the trust board is adequately fulfilling its duties and licence conditions (with the potential for the new shared triple aim (duty) to enhance this power in this respect;*
- *in extremis, NHSI exercising its powers to remove and replace board directors."*

187. NHS Providers added: *"The national bodies should also consider where else barriers to well-founded merger proposals or collaboration exist. For example:*
    - *Do the duties of councils of governors, who have a role in approving significant FT transactions, need revising to ensure a breadth of responsibility towards patient populations beyond their current locality and trust?*
    - *Should the duties of local bodies be revised to emphasise the wider patient population and collaboration in the patient interest?*
    - *How can informal or non-structural collaboration be encouraged and enabled such that a merger is either not required or conversely the ground is better prepared for one? For example, where might joint appointments be made?*
    - *What other means of formal collaboration can be better encouraged or enabled? For example, would alliance or groups, integrated care provider contracts, committees in common, or delegated authorities, be possibilities?"*

188. The original proposal was never intended to affect the system of core accountabilities within the NHS. Moreover, by definition the proposal would only have been used in exceptional circumstances. Although this emphasis on exceptional use appeared to appease concerns of FTs at our national roundtable events, we recognise the concerns from the service. Moreover, we accept the arguments put forward in response to our original proposals that there may be better, alternative ways to achieve organisational mergers where these are clearly in patients' interests through existing regulatory powers and clarifying expectations on provider boards.

189. In light of these reasonable concerns and considerations, we do not now propose that there should be a specific power to direct foundation trust mergers or acquisitions.

190. In circumstances where there is a clear direction from the local system for closer working, but where a FT Board refuses to cooperate, NHS England and NHS Improvement could consider whether the board is complying with its licence conditions relating to governance and, if appropriate, use its regulatory powers of intervention in response to a suspected breach of those conditions. Enforcement action might include requirement on the FT to work with another provider in greater collaboration. Examples may include consolidating back

office functions and/or completing a detailed evaluation and developing a strategic case setting out the rationale for a merger transaction.

191. As an alternative to, or in conjunction with enforcement action, consideration could be given to imposing an additional governance licence condition under section 111, aimed specifically at action required to collaborate with system partners. Then, as identified by NHS Providers above, we could, in sufficiently serious cases use the breach of this additional licence condition as a basis for leadership intervention if needed action was not forthcoming.

192. NHS England and NHS Improvement plan to clarify expectations of FTs regarding their duty to work for the benefit of all patients, not just their own. The new shared 'Triple Aim' duty would provide additional clarity and emphasis to all NHS organisations, including FTs, that they should be working for the benefit of all patients, inside and outside of their organisational structures. This duty would eventually be reflected in FTs' licence conditions.

Survey proposal	572 responses
5b	Give NHS Improvement powers to set annual capital spending limits for NHS foundation trusts

193. Of those individuals and organisations who responded to this question via the online survey, 44.8% agreed or strongly agreed with the proposal, with 25% disagreeing or strongly disagreeing. 30.2% of respondents were neutral towards the proposal.

194. Responses from the provider sector were much more negative – 13 out of 14 FTs were opposed to the extension of capital limits onto Foundation Trusts. By comparison, three out of five NHS trust responses supported expanding capital limits to FTs.

195. Although there was a higher level of disagreement than for other proposals from the survey, many organisations acknowledged that the proposals, and the solutions they are trying to solve, are nuanced: "*there will be circumstances in which a greater degree of national direction would be helpful. Members told us that there were limited examples where certain provider organisations were holding back organisational changes that had the support of other parties in the local system. In these instances, there should be powers to enforce change which is in the interests of the local population. However, safeguards would be needed to establish the limited circumstances under which these powers could be used."* (NHS Confederation).

196. Some respondents saw some benefit in these proposals as a potential tool to encourage non-cooperative providers within a local system to work more effectively with the system. *"In principle Unite supports plans for "a more coordinated and collaborative approach to planning capital investment" in*

principle and supports limiting the freedoms that foundation trusts have been granted where they work against benefit to the whole system approach." (Unite)

197. Other respondents sought clarification on how foundation trusts are viewed within the broader vision for an integrated NHS: *"…raises the question of whether the foundation trust model is something the NHS should try to hold on to, or whether – in a world where organisations are increasingly working collectively in local systems – it is past its sell-by date. This is an area where national NHS bodies will need to be clearer about the broader intended direction of travel, sooner rather than later." (*The Kings Fund)

198. Many respondents queried how the powers of direction on capital limits would play out at local levels. NHS Confederation, in particular, called for "the *adoption of the principle of subsidiarity, which states that powers should be devolved to the most local level possible for effective decision making".*

199. Other stakeholders raised concerns about equity within and across systems. It was referenced that some ICSs are more mature than others. Mature ICS might be more trusted to make transparent decisions for the good of the system. However, for less mature systems, one NHS organisation noted: *"how do we make sure that regional Capital control totals won't always favour shiny new builds and the loudest voices at the table"*.

200. NHS Providers argued that board autonomy and accountability are essential to effective capital investment: *"This proposal fundamentally cuts across provider autonomy and accountability. It is not clear under what circumstances NHS Improvement would be better placed to make a decision about capital investment in local services than the trust board…Simply put, it is unreasonable to take away a board's responsibility for decisions on capital spending but still hold it accountable for providing safe care."* They also expressed a concern that foundation trusts would be disincentivised from saving and building surpluses.

201. Our proposals to set annual capital limits for NHS foundation trusts have clearly sparked a lively debate within the NHS provider sector.

202. The current approach to living within capital limits relies heavily on goodwill and a commitment to reach decisions bearing in mind what is best for patients across whole systems not just those served by individual organisations. This approach should work in most cases.

203. However, where agreement cannot be reached through a collective approach we believe there may be circumstances in which a targeted, reserve power might be necessary to set capital limits on an FT, as suggested by the Health and Social Care Select Committee.

Recommendation 13: To introduce a reserve power to be able to set capital limits on an NHS foundation trust.

204. We are not proposing a general power to set capital limits on FTs. Instead, we are proposing that the power for NHS Improvement to set annual capital spending limits for NHS FTs should be circumscribed on the face of the Bill as a narrow 'reserve power'. Each use of the power should apply to a single named FT individually; automatically cease at the end of the current financial year; and the newly merged NHS England and NHS Improvement should (a) explain why it was necessary; (b) describe what steps it had taken to avoid requiring its use; and also (c) include the response of the FT. To ensure transparency the reasons would be published. To ensure transparency the reasons would be published. The precise form of publication will be a matter for the Bill drafting process. NHS Providers has stated its preference that publication should be in Parliament.

205. We believe that this approach strikes the right balance. It avoids creating a general power to direct all FTs on capital expenditure. The original intention was neither to erode FT autonomy nor cut across the accountability of an FT Board. Nor was it to direct an FT in relation to which individual capital investment decisions they could or could not make within an overall limit. This is now clear through the proposal for a highly circumscribed power.

206. The revised power provides an ultimate safeguard to the taxpayer in the event that an individual trust's actions threaten to breach national capital expenditure limits. This is an issue of equity as well as proper financial management - if one trust's actions breach the capital limit it means capital spending in another community has to be reined back to ensure the NHS as a whole lives within its allotted capital resources.

7. Every part of the NHS working together

Our original proposals

207. Our engagement document invited views on the following proposals:
    - allow Clinical Commissioning Groups (CCG) and NHS providers (NHS trusts and foundation trusts) to create joint committees
    - include provisions relating to the formation and governance of these joint committees and the decisions that could be appropriately delegated to them
    - allow NHS providers to form their own joint committees, which could include representation from other bodies such as primary care networks, GP practices or the voluntary sector

208. To meet the challenges described in the NHS Long Term Plan, the health and care landscape is evolving – moving towards ever-increasing integration and joint working between different organisations at both 'place' (typically borough/council) and 'system' (Integrated Care System (ICS)) level.

209. Our proposals seek legislative change to enable commissioners and providers of NHS services to come together to make legally binding decisions about their statutory functions, in conjunction with other delivery partners including local authorities, primary care providers and independent and voluntary providers. Systems would be able to use the new power as a basis for establishing ICS Partnership Boards to make decisions about their populations. This change introduces another option for increasing integrated system working which is not possible under the current legislation. The powers would also separately enable closer collaboration between two or more providers.

What we heard

Survey proposal	583 responses
6a	To allow CCGs and NHS providers to create joint decision-making committees to support integrated care systems (ICSs)

210. Of those individuals and organisations who responded to this proposal via the online survey, 81.3% agreed or strongly agreed with the proposal, with only 11.6% disagreeing or strongly disagreeing. 7% of respondents were neutral towards the proposal. Of the 82 separate written responses the majority appeared to be either neutral or in the most part did not respond on this issue. Of the remainder the vast majority appeared to agree with the proposal.

211. The broad support was captured by both Doncaster CCG, who noted that the proposal would: *"give the opportunity to increase joint working and speed up the creation of new services"* and Essex Partnership University NHS

Foundation Trust who reflected: *"currently there are restrictions around joint commissioner/provider committees. It will be more efficient to jointly agree, rather than the need for long consultations between parties."*

212. The Health and Social Care Select Committee conclusions also agreed that the law should change to enable clinical commissioning groups and NHS providers to establish joint committees, with appropriate engagement from local government.

213. Therefore, we recommend introducing specific powers in legislation to allow joint committees of CCGs and NHS providers (NHS trusts and foundation trusts) on a voluntary basis. The legislation should be flexible enough to enable joint committees to operate at regional, system and place levels, and with the option for local authorities to participate where locally agreed.

214. We are intentionally not asking for powers to impose joint committees on systems – specifically, it would be counterproductive to insist that all partnership boards in ICSs are joint committees at this point in their evolution. Forcing organisations that are not ready to form such formal relationships is not likely to build trust and collaborative behaviours, negating the positive impact of introducing the proposed change.

215. Several other respondents echoed the Health and Social Care Committee's findings and thought it important for local authorities to engage and participate. This was particularly emphasised as part of proposals for closer collaboration and in relation to the role of health and wellbeing boards.

216. The Local Government Association argued that: *"the NHS increasingly operates within a complex system involving local government, voluntary and community services and private and independent providers, public health etc".* They argued that greater collaboration between NHS and other partners, including local government, needs further consideration within the document.

217. The LGA also called for *"legal reform creating statutory duties which mirror the existing contractual powers and responsibilities in the ICP contract around improving population health and delivering integration, and aligning these with the existing duties on HWBs, local authorities and CCGs to do the same"*.

218. NHS England and NHS Improvement agree that mutual collaboration between the NHS and local authorities is needed for health and social care services to be better integrated. Legislative powers to enable joint working with local authorities already exist under section 75 of the National Health Act 2006. Agreements made under these provisions between local authorities and NHS bodies can include arrangements for pooling resources and delegating certain NHS and local authority health-related functions to the other partner/s,

something that -paradoxically - is not currently always possible between NHS bodies.

219. We want to build on this and agree with the Health and Social Care Select Committee and respondents to our engagement process that local authorities should be expected to and actively encouraged to join joint committees. In particular the LGA welcomed the proposal that local authorities could be part of joint committees where this is locally agreed by all parties.

220. We also recognise the role of HWBs. While we have not heard a need to make legislative changes to their functions, we would expect ICS to work closely with the HWBs in their localities. ICSs will need to pay close regard to the Joint Strategic Needs Assessments and the Joint Health and Wellbeing Strategies.

221. As both local authorities and CCGs are already statutory members of their local HWB, and providers can also be members by invitation, there is no obvious need to legislate to specify the relationship between ICSs and HWBs, as opposed to referencing this clearly in NHS England and NHS Improvement's guidance to ICSs.

222. Various respondents, including the NHS Confederation, Healthwatch England, the Priory Group of Companies and the Royal College of GPs suggested that other organisations should be involved in joint committees, including: voluntary, community and independent sectors, who provide critical services in the local care economy.

223. In addition to CCGs, NHS trusts, foundation trusts and local authorities, we intend that joint committees may also include:
    - **primary care networks** – their representation would be particularly important where the joint committee is the ICS partnership board
    - **voluntary sector** organisations – giving them a "seat at the table" for discussions
    - **other relevant organisations**

224. Local Healthwatch are organised on the same basis as local authority boundaries and this helps ensure they are rooted in local communities. As ICSs develop, it will be important they reach out and ensure effective engagement with their Local Healthwatch organisations.

225. Respondents noted that there should be further detail about the accountability of joint committees.

226. In proposing the ability for commissioners and NHS providers to form joint committees, we do not intend to change existing accountability arrangements of NHS commissioners and providers. There are strong legal duties already in place to require individual organisations to deliver safe, quality care, alongside financial balance, with a clear and understandable accountability up through

NHS England and NHS Improvement to the Government and Parliament – so each organisation would retain its accountability for its individual actions (including those determined on its behalf by a joint committee).

227. Therefore, as with other collaborative arrangements (e.g. those between local authorities and CCGs under section 75 of the 2006 Act), the membership of joint committees of commissioners and providers should be held to account by their constituent organisations for the decisions made by the committee and the range of oversight and intervention provisions for the constituent organisations of joint committee arrangements continue to apply.

228. As constituent organisations are individually accountable for the proper exercise of their own functions in joint committee arrangements, the constituent organisations would determine what functions the committee exercises; set out criteria, standards, principles or success measures to apply to how the committee operates; and decide how and when they will review the committee's performance in respect of these.

229. The Health and Social Care Select Committee said that "*Integrated care systems must not repeat mistakes of the past and become unresponsive monopolies or "airless rooms" where non-statutory alternatives are shut out."*

230. The Committee also reflected: *"The issue of the accountability of integrated care systems (ICSs) and sustainability and transformation partnerships is very important, and not easily solved in the absence of their establishment as statutory bodies. While we agree that it is not advisable at this time to establish all integrated care systems as separate legal entities, in the absence of formal accountability for their collective decision-making, we expect ICSs to meet the highest standards of openness and transparency in the conduct of their affairs by holding meetings in public and publishing board papers and minutes. Transparency, however, is not an adequate substitute for accountability if it is not clear who should be held to account. It is vital to avoid creating a situation where everyone in the system is accountable, but no-one can be held responsible for important decisions. We recommend that the National Implementation Plan due this autumn should set further directions for the standards of governance and transparency local systems should demonstrate."*

231. By virtue of the types of decisions they would make, and the requirements imposed on the constituent organisations, joint committees should ensure transparency and fairness of decision-making. We think that when established as an ICS Partnership Board, joint committees should be required to:
- make decisions in public meetings
- minute and make public its discussions and decisions
- publish papers in advance of meetings
- maintain a publicly accessible register of members' interests
- hold an annual general meeting and publish an annual report

232. In order to effectively fulfil their purpose, joint committees will require the ability to deploy funds flexibly across the functions in which they make decisions, where there is no conflict in doing so.

233. Joint committees would be subject to statutory guidance setting out core requirements about governance, use of public funds and addressing conflicts of interest. It has been suggested that, to create a more formal accountability in local systems, there should be the ability to establish ICSs as formal statutory bodies – i.e. new legal entities, with their own functions (as opposed to joint committees, which are statutory vehicles that allow existing organisations to pool, or make joint decisions about, their functions). We think that joint committees acting as the partnership board in an ICS ensure transparency and formal accountability.

234. A strong message received by the majority of respondents was that to establish ICSs now as formal statutory bodies would not be appropriate. It would necessitate a major change to the NHS's existing organisational and accountability structure; would require a fundamental reassessment of the functions of CCGs, NHS trusts and foundation trusts, and their relationship with national oversight bodies; and would be an unwelcome disruption and distraction at this point.

Recommendation 14: To introduce a facilitative provision in legislation to allow both (i) joint committees of CCGs and NHS providers and, (ii) joint committees of providers only (NHS trusts and foundation trusts)

Survey proposal	579 responses
6b	To allow nurse and secondary care doctor on CCG governing bodies be able to come from local providers

235. Of those individuals and organisations who responded to this proposal via the online survey, 74.5% agreed or strongly agreed with the proposal, with only 11.5% disagreeing or strongly disagreeing. 14% of respondents were neutral towards the proposal. Of the 82 separate written responses the vast majority either stated no preference or did not respond to this proposal.

236. Those that supported the proposal described how it would ensure that CCG governing bodies will have greater knowledge and insight into local provider issues:

- *"we are particularly encouraged by the proposal to allow the designated nurse and secondary care doctor on CCG governing bodies to be clinicians in a local provider. This change will help ensure local clinical expertise and experience is able to shape and influence the design of local services."* (The British Medical Association (BMA))

- *“these proposals will improve the local focus on healthcare provision and are to be welcomed”*. (North Staffs Combined NHS Trust)
- *“we would welcome this as a way of better enabling shared insights between sectors, subject to clear mechanisms for managing conflicts of interest”.* (NHS Providers)

237. Some stakeholders suggested that additional flexibilities in CCG governing body membership could be helpful, including: involving clinicians from mental health and community organisations; allowing all clinical roles; and local government.

Recommendation 15: To allow the designated nurse and secondary care doctor appointed to CCG governing bodies to be clinicians who work for local providers

238. Commissioners and providers are taking a more collaborative approach to support more integrated healthcare and it is no longer proportionate to exclude clinicians from local providers from the CCG governing body as these clinicians could provide the CCG with useful insight. There would be significant benefit from appointing representatives from local providers to these roles, so they can bring the insights of their patients and the secondary care interface into CCG decisions. Therefore, we propose to make a limited change to the requirements of the governing body to remove this restriction.

239. The restriction on specialist members of the governing body was introduced late in the development of the 2012 Act to address concerns raised about conflicts of interest. The exclusion of clinicians from local providers from these roles was intended to reduce the scope for conflicts and based on a clear demarcation between commissioners and providers. In the current and future landscape, commissioners and providers are taking a more collaborative approach in order to support more integrated healthcare and it is no longer proportionate to exclude clinicians from local providers from the CCG governing body as these clinicians could provide the CCG with useful insight.

240. Furthermore, it is inconsistent to allow GPs to sit on governing bodies, but not clinicians from other local providers. There would be significant benefit from appointing representatives of local providers to these roles, so they can bring the insights of their patients and the secondary care interface into CCG decisions. The BMA, in its response to our engagement, has noted that this change *“will help ensure local clinical expertise and experience is able to shape and influence the design of local services. This change would also create parity, in terms of the restrictions that apply, between secondary care doctors and GPs.”*

241. In addition, the current restrictions can be particularly challenging for CCGs that operate over a large population footprint. This is likely to become more of an issue in future as greater numbers of CCGs choose to merge.

242. We therefore recommend a limited change to the requirements of the governing body to remove this current restriction.

Survey proposal	573 responses
6c	To allow greater flexibility for CCGs and NHS providers to make joint appointments

243. Of those individuals and organisations who responded to this question via the online survey, 77.3% agreed or strongly agreed with the proposal, with 9.8% disagreeing or strongly disagreeing. 12.9% of respondents were neutral towards the proposal. Of the 82 separate written responses the majority either did not answer the proposal or made no clear indication of their preference.

244. NHS Providers said that *“many trusts have sought to make joint appointments with CCGs or would welcome the ability to do so. For example, one trust highlighted a joint appointment within their digital team [and] another is seeking a joint director of urgent care and flow.”* West Yorkshire and Harrogate wrote *‘enabling joint appointments between NHS commissioners and providers is welcomed as a freedom which is supportive of collaboration”.* Buckinghamshire ICS said: “*joint appointments save money and encourage better joint working.*”

245. However, the high-level support masked significant disquiet amongst commissioners and others about the difficulty of managing conflicts of interest. For example, the BMA said that *“there is a need for further information as to how these conflicts will be managed”* and the NHS Confederation said, *“we need to manage and mitigate any conflicts of interest.”*

246. NHS commissioners expressed their major concern that the conflict of interest was fundamentally unmanageable at CEO and Director of Finance level. For example, Doncaster CCG said “*it would not be appropriate for statutory roles such as accountable officers and directors of finance.”* NHS Clinical Commissioners has expressed significant reservation about such joint appointments.

247. A few respondents said that we should also facilitate joint appointments with local government and we note there are already a number of these.

248. Organisations that might wish to make joint appointments would need to make an assessment as to whether the appointment should be pursued. This should include an assessment of the conflicts of interest that might arise and whether effective arrangements for these conflicts can be put in place. We would also

need to consider how existing guidance on conflicts of interest should be revised to support the implementation of joint appointments.

Recommendation 16: To introduce a specific power to issue guidance on joint appointments, with a view to providing greater clarity on such appointments across different organisations.

249. We propose consideration is given to whether an explicit power is needed so that NHS England and NHS Improvement issue statutory guidance which could clarify the circumstances in which joint appointments across different organisational types can be made. Given the concerns of CCGs, and the lack of clear consensus, NHS England and NHS Improvement would consult on the application of such guidance.

8. Shared responsibility for the NHS

Our original proposals

250. Our engagement document proposed that NHS commissioners and NHS providers should have a shared duty to promote the 'triple aim' of better health for everyone, better care for all patients and to use NHS resources efficiently.

251. Current legislation places many legal duties on organisations providing and planning NHS services. These are wide-ranging and seek to ensure healthcare is delivered to patients in an effective and efficient manner. However, they do not apply to all organisations equally and have been deliberately designed to give, or interpreted as giving, considerable weight to individual institutions working autonomously to provide or arrange care for specific groups of patients. However, a decision which may benefit one NHS body can have significant and sometimes unforeseen implications for other commissioners or providers, patient care and outcomes.

252. There are limited explicit legislative provisions to ensure the NHS as a whole works together to reach financial balance or to take responsibility for wider population health outcomes. As a result, and despite existing duties to cooperate, organisations naturally work primarily in the best interest of their immediate patients, and place significant emphasis on doing whatever they have to in order to continue to exist as independent organisations.

253. The extent to which local leaders work effectively together across organisations has a significant impact on the health outcomes for local populations. We therefore proposed that a new legal duty be introduced that require those organisations that plan services in a local area (Clinical Commissioning Groups) and NHS providers of care to promote the 'triple aim' of better health for everyone, better care for all patients, and efficient use of NHS resources, both for their local system and for the wider NHS.

254. This statutory duty would support local NHS bodies to work in tandem with their neighbours for the benefit of the local population and to collaborate with neighbouring health systems for the benefit of the wider NHS and the people it serves. They would also help with our goal of strengthening the chain of accountability for managing public money within and between NHS organisations.

Survey proposal	573 responses
7	NHS commissioners and providers should have a shared duty to promote the ‘triple aim’ of better health for everyone, better care for all patients and to use NHS resources efficiently

What we heard

255. Of those individuals and organisations who responded to this proposal via the online survey, 90.5% agreed or strongly agreed with the proposal, with only 2.7% disagreeing or strongly disagreeing. 6.6% of respondents were neutral towards the proposal. This proposal attracted the most support of any in our engagement document, particularly from patients, the public, and their carers:
    - “*Yes, definitely - there needs to be more co-operation and joint working with commitment to shared aims.”* (Member of the public)
    - *“YES, JUST WHAT IS NEEDED.”* (patient)
    - *“This could be seen as THE key aspect for the successful implementation of integrated care systems.”* (Member of the public)
    - *“Yes. The triple aim should be the reason for everything and clear to employees - why they do what they do”* (Charity)

256. Numerous positive responses also were received from professional and membership bodies, the charity sector, as well as NHS commissioners and providers. The Association for Optometrists commented: *“We strongly support this proposal. A shared duty on these lines will encourage all those involved in the provision of local healthcare services to see them ‘in the round’ and seek the most efficient way of providing high-quality healthcare and public health services. This should in turn help to drive the NHS Long Term Plan aspiration of delivering more healthcare in primary settings.”*

257. We propose setting this duty out as a clear need to have regard to the Triple Aim, meaning organisations would need to properly consider whether proposals and their impact are compatible with the Triple Aim, and if not to consider or amend these to better align with system objectives before a decision is made.

258. We received many suggestions for how the definition of the Duty could be strengthened or improved. These were predominantly accompanied by overall support for the proposal.

259. One significant reason for these comments is that there is not currently a universally agreed statement of what is meant by the “Triple Aim”. We would therefore have the option if necessary of setting this out in accompanying

statutory guidance to provide helpful clarity. Broadly speaking, we mean them to be:

Better Care for all patients	The focus of this aim is to improve the patient experience of care, which includes both quality and satisfaction. Quality of care tends to encompass the following attributes: Safe. Effective. Timely. Efficient. Equitable. People-centred.
Better Health for everyone	This aim of "better health for everyone" is to encourage organisations to work together to make the health system work better for everyone. Organisations will be expected to set out how they are considering and working together to think and act on the broader determinants of population health. Consideration of the need to reduce health inequality is a core component of this aim.
Sustainable use of resources	This aim is focused on ensuring the best use of NHS and public resources. Resources is understood broadly to encompass staff, equipment, estates, expertise and money. We propose that "sustainable" is used for this Duty instead of the originally stated "efficient".

260. As set out in the definitions above, we see the need to reduce inequalities as a core component of the Triple Aim Duty. There are existing legal requirements on CCGs and NHS England on reducing inequalities. We do not propose to duplicate existing requirements.

261. Several respondents suggested the duty should be extended to cover staff-wellbeing, including the TUC, the BDA, Unite, the Royal College of Midwives and the Royal College of Psychiatrists. The Royal College of Nurses, who ran a petition on safe staffing suggested: *"As NHS England does not have any explicit legal duties related to the workforce, they would not be mandated to undertake objectives within this area. The legislative proposals do not address this. We welcome the introduction of a shared legal duty. We consider this an ideal opportunity to include a specific legal duty related to the workforce, through expansion of the proposed duty. Workforce planning should be a core component of service design and planning. If not, services cannot be delivered safely or effectively without the right numbers and skills in the right places".*

262. The Health and Social Care Select Committee recommended that the term 'Wellbeing' be used as this was seen as *"a more inclusive term which reflects the contribution local government and the voluntary and community sector make to people's lives. Wellbeing is also an intrinsic part of the World Health Organisation's definition of health."*

263. We accept the Committee’s recommendation. In many circumstances it will be appropriate for NHS decision makers to consider wider wellbeing issues when applying the triple aim duty. We will therefore make this clear in our description of the Triple Aim. We are mindful that that the term “wellbeing” is currently set out in existing legislation, with requirements that go beyond the abilities of NHS organisations into the wider determinants of health. We therefore propose that “wellbeing” is appropriately reflected on the face of the Bill to avoid placing unrealistic expectations on NHS bodies.

264. We also propose that the performance of the Triple Aim Duty will also include a requirement to collaborate with other organisations in order to promote the Triple Aim. The intention is to embed these principles in planning and decision making to reinforce existing duties to engage citizens and patients, to cooperate and to integrate care, as also proposed by the Local Government Association, National Voices and Healthwatch England. We propose that this is reflected on the face of the primary legislation.

265. The new Triple Aim Duty would be consistent with existing legislation, so when collaborating, regard will need to be had to the rules and requirements around consultation, procurement and engagement before agreement to work together is reached.

266. Local authorities would not be subject to the Duty directly, unless under contractual arrangements, but would work closely with the NHS in situations where the Triple Aim Duty applies – including through joint commissioning arrangements with the NHS. Each NHS body would need to ensure that the existing NHS and local authority duties on collaboration, population health and wellbeing, and integration, are fully taken into account alongside the new Triple Aim Duty. There are numerous places where local authorities’ and NHS bodies’ respective duties would most obviously come together, including:
    a. Health and wellbeing boards must, “for the purpose of advancing the health and wellbeing of the people in its area”, encourage commissioners of health and social care services to work in an integrated manner (section 195 of the 2012 Act)
    b. The duty to prepare Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing strategies (JHWS) which set out how those needs will be met, and the duty to have regard to them, applies to both local authorities and CCGs (sections.116 to 116B of the Local Government and Public Involvement in Health Act 2007). The duty to have regard to JHWS also applies to NHS England and NHS Improvement when exercising its commissioning functions
    c. Sustainable Transformation Partnerships cover all of England and enable local NHS organisations and councils to draw up shared proposals to

improve health and care in the areas they serve. NHS England is aiming for all of England to be covered by ICSs by April 2021

d. Joint committees. Our new proposals for joint committees further extend the ability of different providers and commissioners to come together
e. NHS bodies and LAs can enter into section 75 partnership arrangements (including pooled funds)

267. Some responses asked about the implementation of the duty, how it would be measured, how organisations would be held to account for its delivery, whether it would generate additional bureaucracy for providers and commissioners, or if it added anything to existing requirements. The BMA stated: *"we are keen to know how this shared duty will be implemented, especially in cases where it may conflict with an individual organisation's statutory and financial duties. We would also like to know whether organisations will be compelled to comply with this duty; and, furthermore, whether organisations would be open to challenge if they were perceived to not be compliant with this duty."*

268. We also intend to reflect this duty in provider license conditions.

269. The Triple Aim Duty would not be the only mechanism that articulates the need to work for the good of the wider system, nor is it the only tool that enables change in situations where an individual organisation acts in ways that put it at odds with its system.[6] However, the new Duty would help provide clarity to all NHS organisations that they should be working for the benefit of all patients, inside and outside of their organisational structures.

270. NHS England and NHS Improvement (and the merged body) would have oversight of NHS trusts, FTs and CCGs' application of the Duty.

271. Whilst we recognise the appeal of measuring specific outcomes, we do not feel it is effective to set out in statute the precise terms of the triple aim in order to do this, as this would be overly restrictive. We do not propose mandating specific requirements to demonstrate how the Duty has been considered.

Recommendation 17: To place a new statutory Duty on providers and commissioners of NHS services to have regard to the Triple Aim of better care for all patients, better health for everyone, and sustainable use of NHS resources, when considering any aspect of health service provision; and include a requirement to collaborate with other bodies with a view to promoting the Triple Aim

[6] https://improvement.nhs.uk/resources/draft-guidance-good-governance-local-health-economy/

9. Planning our services together

Our original proposals

272. Our engagement document invited views on a number of proposals to enable NHS England and Clinical Commissioning Groups to commission services in a more efficient and coordinated way. Specifically, to:
    - enable groups of CCGs to collaborate to arrange services for their combined populations
    - allow CCGs to carry out delegated functions, as if they were their own, to avoid the issue of 'double delegation'
    - enable groups of CCGs to use joint and lead commissioner arrangements to make decisions and pool funds across all their functions
    - enable NHS England to jointly commission with CCGs the specific services commissioned under the section 7A agreement, or to delegate the commissioning of these services to groups of CCGs
    - enable NHS England to enter into formal joint commissioning arrangements with CCGs for specialised services.

273. Joining up the planning and commissioning of these services by making these changes would complement existing provisions allowing NHS commissioners and local authorities to jointly commission services.

What we heard

Survey proposal	582 responses
8	To make it easier for NHS England and CCGs to work together to commission care

274. Of those individuals and organisations who responded to this proposal via the online survey, 85.9% agreed or strongly agreed with the proposal, with only 4.5% disagreeing or strongly disagreeing. 9.6% of respondents were neutral towards the proposal.

275. The clear majority of the respondents were members of the public and patients. We also received a reasonably large number of comments from CCGs, charities, patient representative organisations and healthcare professionals.

276. Of the further 82 detailed written responses, the responses indicated a significant level of agreement although respondents via this source did not always express a clear preference either way.

277. Overall, the general response to these proposals has been positive, with one of the highest levels of agreement across all the proposals. A large number of respondents provided supportive messages, particularly with regard to the benefits of CCGs working together to commission for their combined population:

- *"These changes would help CCGs and NHS England to operate more flexibly / effectively together in carrying out their functions. The arrangements for pooling / jointly commissioning in an integrated way in a system way is particularly complex for areas such as primary care (delegated) and public health and could significantly be simplified to enabled joined up decision making and focus on outcomes / value."* (Buckinghamshire ICS)
- *We welcome any proposals that provide maximum flexibility for systems to collaborate across the NHS and local government in the planning, commission and delivery of care, both for now and to future proof for possible approaches. It is also appreciated that this increased flexibility would streamline the planning, commissioning and delivery of care. We appreciate there are some technical issues that need resolving such as avoiding the issues of 'double delegation' and would support proposals that facilitate their resolution.* (Herts and West Essex STP)
- *"We have raised a number of concerns around fragmented commissioning pathways, especially relating to mental health and specialised services. We therefore welcome steps to streamline commissioning. Trusts welcome opportunities for CCGs to work together locally across larger footprints to support a population-based approach to health and care, and to improve pathways and care quality. For example, increasing the coordination of commissioning could mean that trusts are able to realise a range of clinical and financial benefits, including economies of scale, efficiencies and quality improvements, as well as reducing duplication in areas such as training, business continuity resilience, and business intelligence services."* (NHS Providers)

278. This theme continues when responding to the proposals on section 7A and specialised commissioning:

- *"We support the proposal to allow NHS England to jointly commission with CCGs services that are currently commissioned under the section 7A agreement or delegate the commissioning of these services to groups of CCGs".* (The Royal College of Midwives)
- *"We welcome the proposals to enable CCGs jointly to commission primary care and public health functions. Many of our members including many commissioners felt this was a positive change, that could help to reduce fragmentation and support more joined up care for patients."* (The NHS Confederation)

- *“We support the principle of more delegation to CCGs for specialised commissioning functions.”* (Bradford District and Craven CCGs)

279. Insofar as significant issues were raised, these mainly related to ensuring clarity of accountability and maintenance of national specialised commissioning standards. Other slightly less frequent themes were closer working and commissioning with local government and governance arrangements. Responses on the proposals for section 7A services and specialised commissioning gave a clear message that the resource and funding for delivering these services should be transferred to the commissioner of the services and that national guidance and standards should remain:
    - “*If it were to be decided that a CCG rather than NHS E would commission a local screening programme, which organisation would be the decision maker on this and what would be the route of consultation between the organisations to get to the decision-making point?”* (Public Health England Screening and Immunisations Team for Cumbria and the North East)
    - *“Regarding the proposal to provide NHS England with the ability to allow groups of CCGs to collaborate to arrange services for their combined populations, we would appreciate further detail on where accountability will lie for commissioning such services. Specifically, whether in such instances there will be individual accountability for the services delivered in a local area; collective accountability between all the CCGs who are collaborating; or whether the lead CCG will be individually accountable for the services delivered across the combined populations.”* (The British Medical Association)
    - “*Although we have been given verbal assurance that national standards for specialised services will be adhered to, we would wish to see this clearly laid out in the proposals.”* (Kidney Care UK)

280. Respondents who made comments in relation to bureaucracy generally believed this would be helpful in joining up the commissioning of services resulting in better outcomes and access to services for patients: *“It is helpful to make things clearer, as we act jointly in this way more and more anyway. We would welcome proposals to extend pooled budget arrangements based on current s.75 (NHS Act) arrangements, however accounting arrangements may not necessarily be straightforward, this needs careful consideration to ensure effectiveness without undue bureaucracy.”* (NHS Devon Contracting team)

281. Specific comments on Local Government highlighted the need to joint working and some respondents raised the current limitations of section 75 of the 2006 NHS Act 2006 which prescribes the services which CCGs and local government can commission and suggested expanding that list further: *“We support a whole system approach to delivering health and care services on a*

‘place’ basis, where ‘place’ in this context means the boundaries of upper tier local authorities. Commissioning, planning and providing section 7a services is undertaken in a challenging complex environment making relationships between services and systems critical.” (Leicestershire County Council).

282. Responses relating to governance were generally broad, with the suggestion of strong governance arrangements being put in place and a suggestion that we include arrangements for all involved in health and social care to work together more easily.

283. Whilst there were not a large number of specific responses on the proposals on section 7A and specialised commissioning, those that did respond highlighted two main themes.

284. The first theme emerging was that when the responsibility for commissioning the services transfers to a CCG or group of CCGs, there should be no shifting of the risk and the resources should follow the function.

285. The second key theme emerging was that it was important when delegating section 7A and specialised commissioning functions, there should still be national standards in place. Respondents welcomed NHS England’s assurance that national standards would continue to apply and sought confirmation, which we give now.

286. The responses have been helpful in aiding the development of the collaborative commissioning proposals. We agree that it is important to have appropriate safeguards in place, particularly when commissioning section 7A and specialised commissioning services. Whilst delegation of public health services could only happen on terms that NHS England considers appropriate, we would suggest introducing specific safeguards in legislation (primary or secondary). These safeguards might include:
    - A requirement for CCGs to produce annual plans for how they propose to discharge the delegated functions, possibly as part of their wider commissioning plan. This would entail consultation with a variety of stakeholders
    - A specific obligation on NHS England to consider how delegated functions are being discharged as part of the annual performance reviews of CCGs
    - Clarity that NHS England can use its powers of direction of CCGs in relation to functions that have been delegated to a CCG – currently, the legislation reads as if NHS England can only direct CCGs in respect of their own functions, rather than those delegated to them
    - Clarity that NHS England can issue guidance to which CCGs must have regard in relation to delegated functions. This would give more flexibility

than having to amend the delegation agreement when NHS England wants to amend an aspect of delegated commissioning
- Specific consultation requirements if a CCG is proposing to delegate the functions to a Local Authority through section75 and an ability for NHS England to veto those arrangements

287. As NHS England would only enter into joint commissioning arrangements for specialised services rather than delegation of these services to CCGs, NHS England would remain accountable for this commissioning, which would continue to be supported by national standards of care, service specifications and clinical policies determined by NHS England.

288. We are separately proposing to update the list of prescribed services that CCGs and local government can commission under section 75 of the 2006 Act. This would be through secondary legislation.

Recommendation 18: To allow groups of CCGs to be able to use joint and lead commissioner arrangements to make decisions and pool funds across all their functions

289. To facilitate governance arrangements and reduce the risk of challenge to CCG decision-making where joint committees and committees in common meet at the same time and place, we propose to enable groups of CCGs in joint and lead commissioner arrangements to make decisions about and pool funds across all their functions, with a few exceptions.

290. We propose that the following CCG functions should continue to be excluded from joint arrangements, so they remain the responsibility of the individual CCG:
    - having a governing body
    - having an audit committee
    - having a remuneration committee
    - applications for variation of constitutions, merger, dissolution etc
    - maintaining a register of interests
    - ability to exercise functions with third parties (individual CCGs should always retain decision-making rights about this; not retaining this function would create a double delegation issue)
    - matters reserved by member practices in the CCG's constitution that cannot be part of joint or lead arrangements

291. This change would allow groups of CCGs to use a joint committee or lead commissioner arrangements for both commissioning and corporate functions. CCGs in STPs and ICSs are currently planning what decisions they should

make across the system in future versus what decisions should be made at place or CCG level. The proposal would ensure that groups of CCGs working across a STP or Integrated Care System footprint can – where they choose to do so – make decisions across all their functions in a joint committee.

Recommendation 19: To allow CCGs to carry out delegated functions, as if they were their own, to avoid the issue of 'double delegation'

292. This amendment should address the "double delegation" issue, allowing CCGs to make collaborative arrangements for services delegated to them by NHS England – this would enable combinations of CCGs and local authorities to work together to commission care across a wider range of services. We also propose to make clear that liabilities arising from the discharge of delegated functions lie with the CCG rather than with NHS England e.g. in relation to procurement challenges.

293. This change would further empower CCGs to make joint decisions about planning and delivering care. NHS England would retain overall responsibility for these functions, but CCGs would have the freedom to work jointly with other CCGs and/or local authorities to promote greater integration of local services.

294. Under these arrangements NHS England would continue to be accountable for its functions but when we delegate services CCGs would be responsible for them. We would use our powers in relation to oversight to scrutinise whether the CCG was itself holding 'double delegates' to account and checking that they were exercising functions appropriately. A CCG could be identified as failing if it had delegated a function but not taken appropriate steps to ensure this was being carried out.

Recommendation 20: Give NHS England the ability to delegate its functions to groups of CCGs, in order to enable them to collaborate more effectively to arrange services for their combined populations

295. We are proposing that the law is amended so that groups of CCGs can come together to make decisions for their combined areas about delegated services. We also propose changing the legislation so that NHS England is able to make joint decisions about its functions with a group of CCGs across their combined areas (e.g. in an ICS arrangement). At present, NHS England is only able to delegate functions to individual CCGs, limiting the scope to commission services across a wider geographical footprint where this makes sense for patients and local communities.

296. Existing powers in the 2006 Act enable joint commissioning or delegation of these NHS England functions to a single CCG; or through changes resulting

from the Cities and Local Government Devolution Act 2016, to a CCG and local authorities or combined authority. Our proposals would future-proof the current legislation by enabling groups of health bodies to have this same flexibility to make arrangements for primary medical care, primary dental services, community and other prescribed secondary dental services, core pharmaceutical services, ophthalmic services, armed forces healthcare, and health and justice services alongside their other health services.

297. This flexibility would not be without safeguards. Specific proposals to delegate or jointly commission e.g. armed forces healthcare or health and justice services would need to demonstrate that they have a clear supporting rationale, as there are benefits in having a single national model to deal with these specific groups of patients. Whilst delegation could only happen on terms that NHS England and NHS Improvement considers appropriate, we plan to introduce specific safeguards in legislation (primary or secondary) – not least if we propose to enable pooling of budgets.

Recommendation 21: Enable NHS England to enter into formal joint commissioning arrangements with CCGs including providing the ability to pool budgets in relation to specialised commissioning

298. These changes are in line with our recommendations for collaborative commissioning of NHS England's wider directly commissioned services, allowing for a single set of arrangements between NHS England and a number of CCGs. Without these changes, CCGs and NHS England would not be able to make decisions about specialised services in joint committee arrangements. Moving to place-based arrangements for specialised commissioning does not represent a move away from a fair and consistent approach to specialised service provision throughout the country. NHS England would remain accountable for commissioning specialised services, which would continue to be supported by national standards of care, service specifications and clinical policies determined by NHS England.

299. The changes would also ensure that CCGs have a genuine stake in specialised services decision-making and spending of pooled resources, enabling integration of these services into wider care pathways within the terms of the joint arrangements. We are aware that the ability to make joint decisions and spend the pooled funds (including any surplus) is limited to those functions in the joint arrangement.

300. In addition, as is the case for other functions that NHS England can jointly commission, we propose that the legislation clarify that budgets can be pooled under such joint commissioning arrangements, to enable the smooth implementation of joint decisions about improving patient pathways.

Recommendation 22: to remove the barriers for NHS commissioners to enter into collaborative arrangements or section 7A functions that will enable these commissioners to work with others and make decisions about delivering statutory functions – both their own and those delegated to them

301. The proposed changes would allow:
    - delegation of section 7A commissioning to groups of CCGs (e.g. in an ICS arrangement) so that they can enter into the same range of collaborative arrangements as for their own functions, make joint decisions about section 7A functions across their combined areas and provide population coverage as per national standards
    - for CCGs that have section 7A functions delegated to them to enter into the same range of collaborative arrangements as for their own functions, so that they can make joint decisions about section 7A functions and provide population coverage as per national standards, including through joint committee and section 75 partnership arrangements
    - allow NHS England to enter into joint commissioning arrangements for section section7A functions with one or more CCGs, including through joint committee arrangements and, to enable commissioners to make section 75 partnership arrangements and joint committee arrangements in respect of section 7A functions.

302. As the thrust of our proposals seek to prioritise delivery of integrated care, these changes would enable arrangements for section 7A services to be on the same footing as that of other NHS England functions, i.e. to have the ability to jointly commission with, or delegate to, one or more CCGs so that local areas are able to make joined-up decisions about services for their populations.

303. Delegation and joint commissioning of section 7A services with one or more CCGs would enable local input into public health commissioning, whilst still retaining a consistent national approach where this works best.

10. Joined up National Leadership

Our original proposals

304. The public largely see the National Health Service as a single organisation. Parliament expects the whole of the NHS to work together to make the best use of its collective resources for the greatest benefit for patients. Health and care organisations are increasingly working together to improve care for their populations and want the national leadership to speak with a single voice. It is right that the national organisations of the NHS work more closely together.

305. In its June 2018 report, the Health and Social Care Select Committee concluded that local bodies' experience of national arms-length bodies (ALB) was *"one of competing priorities that perpetuate existing divides between services and encourage organisations to retreat into individual silos".*

306. As the organisations with most responsibility for setting the direction of and overseeing the NHS, NHS Improvement (comprised of Monitor and NHS Trust Development Authority) and NHS England are already working closely together to align operating models, Board and committee arrangements, and appointments through the Joint Working Programme. However, as separate statutory bodies, there are limits on the extent to which NHS England and NHS Improvement can work together.

307. Our engagement document proposed a closer union between NHS England and NHS Improvement by either merging or further aligning their functions. The survey asked which of these options to join up national leadership was preferred
    - Formally combine NHS England and NHS Improvement
    - Provide flexibility for NHS England and NHS Improvement to work more closely together
    - Neither of the above

What we heard

Survey proposal	556 responses
9a	To bring NHS England and NHS Improvement together more closely, either by: a) combining the NHS England and NHS Improvement; or b) providing flexibility for NHS England and NHS Improvement to work together closely

308. Of those individuals and organisations who responded to this proposal via the online survey, 57.4% preferred option (a) to combine NHS England and NHS Improvement, 32.7% preferred option (b) to provide more flexibility for the two

organisations to work together. 9.9% of respondents thought were neutral towards the proposal. Of the separate written responses, there was not a clear preference between the two options but a clear recognition the national bodies should be more aligned.

309. Overall, responses were supportive of the principle, but were keen to understand more detail, including on how it would work regionally, including with local government/social care.

310. A clear reason for supporting a merger and/or closer working was that it should end separate messaging from centre, reduce bureaucracy and offer an opportunity to provide integrated system leadership. NHS Clinical Commissioners commented: *"Combining some functions held by NHS England and NHS Improvement are welcome, as CCGs working in their local systems have experienced duplicative and at times conflicting information and regulation."*

311. NHS Providers responded: *"Trusts for some time have told us they want NHSE and NHSI to work more closely together and provide single, integrated, system leadership of the NHS, whilst ensuring a clear understanding of provider needs and the ask made of them".*

312. North Staffordshire Combined Healthcare NHS Trust noted: *"The Trust does have experience of working in a regulatory environment where different national bodies have exerted opposing influences onto the system which has hindered the ability of NHS system partners to work collaboratively."*

313. Mid Essex Clinical Commissioning Group: *"We have experience in our health system of NHS Improvement approving RTT trajectories with providers that are different to trajectories set with commissioners by NHS England. Two different regulators ostensibly reviewing the same overall health economy is not helpful and causes more problems than it solves."*

314. The Health and Social Care Committee commended NHS England and NHS Improvement for the efforts already made to work closer together and recognised further progress is hampered by the legislation covering the two bodies. The Committee concluded*: "In an era of local systems, the NHS at a national level should operate with one voice, so as to avoid any incoherence in the support, guidance and direction local systems receive. We support in principle the proposal to merge NHS England and NHS Improvement into a single body but await further clarity on the implications of the creation of a single organisation."*

315. Support was widespread but not universal. Social Enterprise UK were one organisation who did not support a merger: *"Collaboration between NHS Improvement and NHS England is important, but we believe that both retain*

distinctive roles. It is important that NHS Improvement remains separate with a focus on the overall efficiency and effectiveness of the NHS, with NHS England focused on budget planning and delivery of the commissioning of NHS services."

316. Overall, closer working between NHS England and NHS Improvement is the agreed direction of travel. The responses confirmed that we should legislate to create a single organisation. This is also the clear stated public preference of the Boards of both NHS England and NHS Improvement.

317. We propose the legislative mechanism to achieve this should be to merge the functions of Monitor and TDA into the NHS Commissioning Board (NHS England) with appropriate modifications to those functions and some potential new functions. The "new" organisation would therefore be an existing statutory body, with the functions and staff of the other two national organisations transferred to it, with limited further change (other than the changes to functions proposed elsewhere in our proposals).

318. The Health and Social Care Select Committee said: "*When these proposals come before us again, one of the issues we will want to consider very carefully is how local autonomy will be protected under the new arrangements."*

319. In short, our proposal would establish a single legal entity answerable to the Secretary of State for Health and Social Care and Parliament responsible for all aspects of NHS performance, finance and care transformation.

320. To achieve this, we propose extending NHS England's mandate under section 13A of the 2006 Act to apply to its new provider functions as well as its existing commissioning functions. Similarly, its duties to prepare a business plan and annual report (ss. 13T and 13U) and its additional powers under sections 13W to 13Y (powers to make grants etc). This would enable Department of Health and Social Care to publish a single set of statutory objectives, as well as include requirements (which can be given a legal basis) for all the functions of all three current bodies. This is currently only possible for NHS England.

321. Accountability obligations and structures that are in place for provider and commissioner functions within the current ALB would be maintained unless removed by other proposals set out in this document (such as Monitor's competition functions). These numerous and significant lines of national accountability back to Secretary of State, Parliament and the Department of Health would continue to be in place, whilst clarity and transparency would be improved through the expanded Mandate.

322. In response to the Health and Social Care Select Committee we have therefore ensured our proposals does not encroach on the local autonomy of providers and commissioners. The main concern has been in relation to the original

provisions to direct mergers and set capital limits and we have now proposed to drop the former and highly circumscribe the latter. With that sole exception, we do not propose creating new powers of direction for the single body, nor reducing autonomy threshold for intervention. As our published joint working proposals commit, our regional teams are increasingly seeking to rebalance their necessary continued focus on system oversight with stronger support for supporting improvement. Overall the proposals in this document are to leave the powers of intervention as now at all levels of the NHS.

323. The overwhelming response from this engagement is that the previous statutory institutional tension between ALBs has not worked and is getting in the way of implementing the NHS Long Term Plan. The problem we face now is not insufficient but excessive separation of interest, resulting as we have heard in sometimes unhelpfully divergent and unreconciled views.

324. Transparency would be improved through aligned accountabilities across provider and commissioner responsibilities, and decisions would continue to be made in public.

325. There were some points raised to ensure the services that are currently offered by the organisations are retained: *"Whatever the final arrangements are, it is vital that foundation trust governors, or their equivalents, have access to independent advice and guidance as currently provided by NHSI"*. (Individual Board Governor)

326. Similar concerns were expressed in reverse by CCGs.

327. Our argument is that rather than advocating for providers in isolation or commissioners in isolation, the NHS Long Term Plan demands that we instead need to take a 'one NHS' approach.

Recommendation 23: To create a single organisation which combines all the relevant functions of NHS England (NHS Commissioning Board) and NHS Improvement (TDA & Monitor)

Survey proposal	564 responses
9b	To provide Secretary of State the power to transfer, or require delegation of, Arms-Length Body (ALB) functions to other ALBs, and create new functions of ALBs, with appropriate safeguards

328. Of those individuals and organisations who responded to this proposal via the online survey, only 40.3% agreed or strongly agreed with the proposal, with 17.9% disagreeing or strongly disagreeing. A greater proportion of respondents, 41.8%, were neutral towards the proposal.

329. Overall, we did not find any significant patterns in the online or written stakeholder responses. Some respondents said that there wasn't enough detail to make a clear judgment on the proposal, such as the motivation or rationale for needing the power or how and when it might be used.

330. We saw a lot of opposition, particularly that the power could be used to reduce the statutory independence of national bodies. The Kings Fund noted: *"We are puzzled as to the motivation behind this proposal and – in the absence of further information – we are concerned that this could be very broad and have far-reaching implications, including reduced autonomy for NHS arm's length bodies and greater scope for political intervention in the NHS. Our view is that much more detail is required to understand the intention behind this new power; when and how it might be used must be set out clearly in legislation."*

331. The Health and Social Care Select Committee also concluded: *"We would like more clarity on how establishing powers for the Secretary of State to transfer powers to arms-length bodies (ALBs) or require ALBs to delegate their functions to another ALB, will be used to support the delivery of the NHS Long-term Plan and the goal of better integration. The strategic intent behind this power is unclear."*

332. Some respondents were clear that safeguards were needed on such a power, through either a statutory consultation with affected stakeholders whenever seeking to use the power or through Parliamentary scrutiny – for example, of a statutory instrument. Several respondents raised a concern that this power might lead to costly and disruptive restructures in the NHS without appropriate safeguards.

333. Some respondents raised concern that the power could reduce accountability and transparency as the roles and responsibilities of organisations could become less clear. Some respondents raised concern about potential far-reaching local impacts, especially from the power leading to large national organisations that diminish the power of local bodies. Respondents suggested this might erode the principle of subsidiarity.

334. The Local Government Association noted: *"we want a … commitment that any consolidation at national level leads to more streamlining and join up locally. Furthermore, the NHS national arms-length bodies must consider what impact any changes would have on transparency and accountability of NHS decision-making at a local level, with an emphasis on devolving decision-making to the most appropriate local level, in order to promote the principle of subsidiarity."*

335. NHS Providers also observed: *"While some rationalisation of ALBs may be helpful, we must be mindful of the tendency of different governments to reorganise the NHS. There is also the potential within this approach that principles of subsidiarity and risk-based regulation are eroded over time. We*

should also remember the original intention of creating NHS England in particular as a means of lessening the politicisation of the service. In creating this power, it will be important to ensure that in exercising it, the Secretary of State is required to formally consult those affected by the intended changes before they go ahead."

336. Several arm's length bodies responded to the engagement. They raised some of the common themes such as the need for more detail and for clear safeguards on a power. Health Education England commented: "*if this proposal is taken forward, any system realignment should be underpinned by a rational and strategic approach. This should include a set of transparent public criteria to be applied when considering transfers…Any exercise of powers by the Secretary of State to transfer ALB functions to other ALBs and create new ALB functions should be subject to consultation with stakeholders."*

337. Care Quality Commission said to the Health and Social Care Select Committee: "*we do not think any legislation would be needed for CQC specifically in the short term. As new models of care develop over time, and integration changes the current provider landscape, the kind of regulation required may change; but it is too soon to know how that may affect CQC's legislation. For this reason, we are not seeking any changes in the short to medium term"*

338. Overall it is clear from the response that the specific suggestion on creating a new Secretary of State power does not enjoy consensus within the NHS. 40% of respondents were positive about this proposal as opposed to a majority of respondents being in favour of our other proposals. The Health and Social Care Select Committee felt unable to support the proposition without greater clarity.

339. A separate but related question is the respective responsibilities of national organisations in relation to workforce functions.

340. That question formed part of a wider petition organised by the Royal College of Nursing, who said that: *"Expanding powers for the Secretary of State for Health and Social Care provides a clear opportunity to articulate the new duties for workforce that we have called to be included in this legislation".*

341. A number of other respondents felt there should be greater clarity on which organisations are specifically responsible for ensuring adequate levels of funding for NHS staffing, including UNISON, and also the Royal College of Physicians: *"the inclusion of a specific duty on the Secretary of State for Health and Social Care to ensure that there is sufficient workforce to meet the health and care needs of the population. Roles and responsibility of Arm's Length Bodies (ALB) should also be clarified, ensuring that all the policy levers they need to ensure that the NHS has the workforce strategy and resources it needs are in place"*

342. In responding to the RCN, UNISON, and other royal colleges, we recommend that the Government should now revisit with partners whether national responsibilities and duties in relation to workforce functions are sufficiently clear.

11. Equalities impact

343. It is important that our response and final recommendations consider any potential impact on equality. In our survey we asked respondents the following question: *Beyond what you've outlined above, are there any aspects of this engagement document you feel have an impact on equality considerations?*

344. Of the 624 responses we received online, 13% of respondents commented on the equalities question. Of the 82 narrative responses from stakeholder organisations, 13% also commented on the issue. In the responses there were specific mentions of vulnerable groups including people with long term chronic conditions, black and minority ethnic people, people with sensory impairments, nomadic gypsy and traveller communities and carers.

345. Across all of these responses we saw some key themes emerge:
- highlighting the importance of patient experience and local engagement
- the need to carry out an equality impact assessment
- how greater collaboration could help to promote equality
- the need to address health inequalities including in rural areas
- involving other sectors such as local government and mental health
- impact of any changes on patient choice

346. On patient experience and local engagement, The Royal College of Child Health and Paediatrics commented that: "*It should be unacceptable for any CCG/NHS organisation to ignore any part of the population and bringing together a diverse group of individuals and organisations to represent the range of staff groups, ages and ethnicities will help to prevent this."*

347. Other responses mentioned the potential positive impact the proposals could have on equality and patient and public engagement. The Academy of Medical Royal Colleges said: "*moving to a system of collaboration as opposed to competition should have a positive impact on both equality of access to services and equity of provision."*

348. Reinforcing this view, Sussex and East Surrey Clinical Commissioning Group suggested: "*these proposals should enable better, more joined up and less bureaucratic approaches to the commissioning, delivery, governance and regulation of integrated health and care services. This will help us to better focus on and address the diverse and differential needs of all of our communities, achieve better value and services for our patients, enable better patient involvement in designing the services our population receives, and more effectively tackle the health inequalities that exist in Sussex and East Surrey."*

349. We received a number of responses on health inequalities, including the impact on rural communities. Lincolnshire County Council's Health Scrutiny

Committee: “*the challenges of delivering health and care services in rural areas, where travel and transport can be a challenge.”*

350. A full equalities impact assessment would be carried out in relation to any Bill introduced in Parliament. Such an assessment will fully explore the effect of our proposals across all equality areas and protected characteristics to ensure we are meeting the needs of vulnerable groups.