

Implementing the NHS Long Term Plan

Proposals for possible changes to legislation



Implementing the NHS Long Term Plan: Proposals for possible changes to legislation

Engagement Document

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Introduction

We are inviting patients, NHS staff, partner organisations and interested members of the public to give us your views on potential proposals for changing current primary legislation relating to the NHS.

The success of the NHS Long Term Plan depends on our collective will to change the NHS for the better and improve services for everyone working in them and using them. Local NHS bodies need to be free to work together with partners, including local authorities, to plan and provide care around patients, not services or institutions, and the same is also true for our national organisations.

It's possible to implement the NHS Long Term Plan without primary legislation. But legislative change could make implementation easier and faster. Local NHS bodies need to be better able to work together to redesign care around patients, and the same is also true for the national bodies. And the rules and processes for procurement, pricing and mergers create unnecessary bureaucracy that gets in the way of enabling integration of care.

We outlined eight groups of suggested legislative changes in the NHS Long Term Plan and, as promised in the Plan, are now setting out further detail. It is based on what we've heard from patients, clinicians, NHS leaders and partner organisations, as well as national professional and representative bodies, and it is intended to better enable NHS organisations to work collectively. These proposals are designed to solve specific practical problems that the NHS faces and avoid creating operational distraction.

You can take part and ensure your voice is heard by completing the short survey which is available online at:

<https://www.engage.england.nhs.uk/survey/nhs-long-term-plan-legislation/>.

You can also provide more detailed feedback and comments through this online template for responses.

We want to hear from as many people as possible and intend to share the feedback we receive with the Parliamentary Health and Social Care Select Committee to inform their inquiries. We invite views by 25 April 2019. We encourage as many individuals as possible to complete the survey.

1. Promoting collaboration

1. We propose targeted changes to enable collaboration. The Health and Social Care Act 2012 formalised the role of the Competition and Markets Authority¹ (CMA) in reviewing certain NHS transactions and assigning new responsibilities to Monitor. Competition can in some circumstances help provide benefits to patients – for example in the supply of pharmaceuticals – and we therefore propose a more nuanced approach that gives due weight to collaboration. That is why we are proposing changes to both the CMA’s and NHS Improvement’s (Monitor) roles in respect of competition.
2. The CMA has powers to investigate alleged infringements of competition law and investigate particular markets if it sees issues for consumers with reducing competition. The CMA has used these powers to ensure that public interest has been an important part of regulating private companies in the health and healthcare market. We can see clear benefit in the CMA continuing this role.
3. 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 provider mergers or acquisitions in recent years. Whilst it has approved all the mergers it has considered, with the one exception of its first investigation into the proposed merger between Poole Hospital NHS Foundation Trust and Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust, the investigations have been costly and time consuming for the organisations involved.
4. **We propose that the CMA’s function to review mergers involving NHS foundation trusts should be removed.** Instead NHS Improvement would continue to review proposed transactions, including mergers or acquisitions, to ensure there are clear patient benefits.
5. NHS Improvement’s primary role is to support improvement in the quality of care and use of NHS resources. In line with this, **we propose NHS Improvement’s competition powers and duties should be removed.**
6. NHS Improvement (as Monitor) is 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. NHS Improvement (as Monitor) is also responsible, with NHS England, 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

¹ More information about the role of the CMA can be found [here](#)

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. We consider that NHS Improvement – together with NHS England in the case of the National Tariff Payment System – should be able to reach final decisions on these matters without referral to a competition authority, provided it has consulted on the proposals and given proper consideration to any concerns that are raised.

- 7. We propose that the need for NHS Improvement to refer contested licence conditions or National Tariff provisions to the CMA should be removed.**

2. Getting better value for the NHS

8. In this section we propose targeted amendments to primary legislation to free the NHS from overly rigid procurement requirements. These would be replaced by a new best value test and stronger protection for patient choice.
9. Procurement of health care services in the NHS is carried out under two sets of regulations: the so-called section 75 regulations², made under powers in the Health and Social Care Act 2012, and the Public Contracts Regulations 2015, which implement EU rules on public procurement. The two sets of regulations overlap in terms of some of their requirements but following one of them does not automatically mean a commissioner is meeting the requirements of the other. Under the Public Contracts Regulations, contracts over a certain amount (£615,278 over the lifetime of the contract) need – with some limited exceptions – to be advertised and the applicable procurement procedures must be followed.
10. Current procurement legislation can lead to protracted procurement processes and wasteful legal and administration costs in cases where there is a strong rationale for services to be provided by NHS organisations, for instance to secure integration with existing NHS services. It also makes it more difficult for NHS organisations to ensure they are using their collective financial resources in the most effective way for local populations. Furthermore, the current legislation can discourage NHS organisations from collaborating to develop new models of care, in case this is challenged on the grounds of not treating all providers equally.
11. There should be a continued place for the use of competitive procurement, either by NHS commissioners or by integrated care providers, to bring in new capacity or innovative service models. To achieve best value commissioners should have discretion, subject to a best value test, as to when to seek interest from other potential healthcare providers, rather than arrange for NHS organisations to provide services.
12. **We propose that the regulations made under section 75 of the Health and Social Care Act 2012 should be revoked and the powers in primary legislation under which they are made should be repealed and replaced by a best value test.**
13. Requirements in relation to patient choice would continue under the separate regulations which currently impose requirements ('standing rules') on commissioners, as well as licence conditions for providers. We propose that the

² The National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013.

power to set standing rules in primary legislation is explicitly amended to require inclusion of patient choice rights. The NHS Long Term Plan makes specific proposals to strengthen patient choice and control, including the roll out of personal health budgets. We anticipate these will be set out as additional requirements for commissioners under the standing rules.

14. **We also propose that arrangements between NHS commissioners and NHS providers are effectively removed from the scope of the Public Contracts Regulations and that NHS commissioners are instead subject to a new 'best value' test when making such arrangements, supported by statutory guidance.**
15. The new regime would allow NHS commissioners to choose either to award a contract directly to an NHS provider or to undertake a procurement process, with the clear aim of ensuring good quality care and value for money when designing local healthcare services. It would give commissioners freedom to engage widely with existing providers to design the model of care they want before awarding a contract, whether via a procurement process or otherwise. And it would allow them to choose how they oversee contracts with NHS providers and amend them as they see fit when healthcare needs change.
16. The key tests would be whether NHS commissioners were obtaining 'best value' from their resources in terms of the likely impact on quality of care and health outcomes, whether they were acting in the best interests of patients, and whether they were actively considering relevant issues in making any decisions, for example, the improvement progress a particular provider is making in tackling unwarranted lower outcomes than their peers.

3. Increasing the flexibility of national NHS payment systems

17. The National Tariff Payment System ('tariff') is a set of currencies (e.g. defined episodes of care), prices and rules governing the payments that NHS commissioners make to providers for NHS-funded healthcare (except for primary care services). It is intended to promote high-quality care and improve the efficiency with which services are provided. The tariff is set on an annual or multi-year basis.
18. The NHS Long Term Plan describes how we are already developing the tariff to support stronger collaboration and to provide shared incentives for commissioners and providers to improve quality of care and efficient use of resources, for instance the proposed move (subject to the outcome of the statutory consultation that closed on 21 February) from a 'cost per case' approach for paying for acute emergency care and instead using a much greater proportion of resources to recognise the fixed costs that hospitals incur in providing emergency care. Choice will still exist for elective care and money will need to continue to follow patients accordingly.
19. The tariff already offers significant flexibility to support new ways of delivering care. Providers and commissioners are able to agree local payment approaches, provided they are in the best interests of patients, promote transparency and result from engagement between providers and commissioners. However, we believe that legislative changes could help provide more flexibility in this respect.
20. **Specifically, we propose that legislation should:**
 - **allow national prices to be set as a formula rather than a fixed value, so that the price payable can reflect local factors;**
 - **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.**
21. Currently, providers can in certain circumstances apply to NHS Improvement (as Monitor) to make local modifications to national prices. This is arguably out of keeping with the move to integrated care systems (ICSs) in which NHS

commissioners and providers take shared responsibility for managing their collective financial resources and agree how best to use those resources to improve quality and outcomes. **We propose that, once ICSs are fully developed, the power to apply to NHS Improvement to make local modifications to tariff prices should be removed.** Commissioners and providers would continue to be able to agree local modifications to national tariff prices to reflect local circumstances.

22. It is not currently possible to set national tariff prices for 'section 7A' public health services commissioned by NHS England or Clinical Commissioning Groups (CCGs) on behalf of the Secretary of State. This has created difficulties where these services are part of a patient pathway for a particular service, for example, screening new-born babies' hearing as part of their mothers' maternity care.
23. Subject to proposals later in the document on the future arrangements for commissioning 'section 7A' public health services, to support integrated care **we propose that primary legislation should be changed so that the national tariff can include prices for 'section 7A' public health services.**

4. Integrating care provision

24. Health and care services for a local population are commissioned by different organisations and delivered by a range of separate provider organisations under different contracts, with different funding arrangements. Through the development of ICSs, those different commissioners and providers are increasingly coming together to plan services in a much more collaborative way. Some local health systems have expressed interest in going further and bringing some services together under the responsibility of a single provider organisation, supported by a single contract and a combined budget. They consider that this would enable them to make faster progress in developing integrated care for a local population, and provide stronger incentives and opportunities for provider organisations to prioritise action to prevent ill-health and improve population health.
25. In response to this, the NHS has developed the Integrated Care Provider (ICP) contract to enable the integration of services under a single contract. This could be for primary care and other community-based health services, potentially including public health and/or social care services, or it could also include acute hospital services. The ICP contract is a discretionary and flexible tool for local commissioners: it is for them to decide in the light of local circumstances whether to bring services together using ICP contracts and, if so, which services should fall within the scope of the contract.
26. The provider organisation that holds an ICP contract would not necessarily provide all the relevant services itself – it might well subcontract with other providers, such as local GP practices or voluntary sector organisations to provide some services. While the contract holder will continue to be accountable to commissioners, the ICP contract gives the contract holder overall responsibility for deciding how to use resources to improve quality of care and health outcomes for a defined population.
27. In some cases, it may be difficult for commissioners to identify an existing organisation that could take on responsibility for a contract of this kind. If, for instance, a group of local GP practices and a provider of community, mental health and/or hospital services wished to come together to become an integrated care provider, they might wish to establish a new NHS organisation that exists solely for the purposes of providing integrated care. The existing legislative framework does not, however, lend itself to these circumstances.
28. One way to overcome this challenge would be to give the Secretary of State clear powers to establish new NHS trusts for the purposes of providing integrated care. Taken together with the procurement changes proposed elsewhere in this document, this would also support the expectation in the NHS

Long Term Plan, and the Health and Social Care Select Committee's recommendation, that the ICP contract should be held by public statutory providers.

29. **We therefore propose that the law should be clarified so that the Secretary of State can set up new NHS trusts to deliver integrated care across a given area.** These 'integrated care trusts' would 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.

30. The resulting 'integrated care provider' would:

- have a contractual duty to deliver and improve health and care for a defined population;
- act as a provider of integrated care with the freedom to organise resources (money, staff, and facilities) across a range of health and care services, working – as appropriate – in conjunction with other local partners;
- be run in a way that involves the local community and the full range of health care professionals, including GPs; and
- be accountable to commissioners for its performance.

5. Managing the NHS's resources better

Establishing the best leadership and governance arrangements for local health services

31. NHS providers collectively deliver around £75bn of publicly funded services each year. In recent years, it has become increasingly common for NHS provider organisations to come together, through mergers or acquisitions, so that a single organisation can plan and deliver services better across multiple local sites. This can allow the NHS to manage its resources – its workforce, its buildings and other capital assets, its knowledge and insights – better, for instance by developing standardised approaches to service design and continuous quality improvement; improving approaches to recruiting, retaining and developing staff; and sharing back office and clinical support services.
32. Recent examples of trusts joining forces in this way include the former hospital trusts in Central Manchester and South Manchester (now Manchester University NHS Foundation Trust), the former trusts responsible for four hospital sites across Birmingham (now University Hospitals Birmingham NHS Foundation Trust) and the former hospital trusts in Ipswich and Colchester (now East Suffolk and North Essex NHS Foundation Trust). These and other similar developments are helping to ensure that services across the different sites managed by the unified trust remain clinically and financially sustainable, continuing to provide both efficient and high-quality care to local communities. In some cases, they are also providing the basis for 'group' models, where the headquarters of the unified trust develops more standardised approaches to service planning, workforce planning and corporate functions, avoiding duplication of effort across its sites. The clinical and managerial leadership in each of the constituent sites is able to focus more of its attention on the day-to-day running of services and strengthening links with its local community partners.
33. Although most recent developments have involved hospital trusts, the same approach can potentially bring comparable benefits for any area of NHS care and for integrated care.
34. Wherever possible, we would want local provider organisations and their system partners to agree where improvements of this kind are needed and how to take them forward. In some circumstances, however, such improvements could be frustrated by the reluctance of one local trust to consider such arrangements. Whilst NHS Improvement (exercising the powers of the Secretary of State) can direct NHS trusts in this respect, current primary legislation allows NHS Improvement to take equivalent action in relation to NHS foundation trusts only

in the extreme circumstances of trust special administration, in other words only where there is a serious failure or risk of failure.

35. **We are proposing that NHS Improvement should have targeted powers to direct mergers or acquisitions involving NHS foundation trusts, in specific circumstances only, where there are clear patient benefits.** This provision would need appropriate safeguards. We propose specifically that NHS Improvement should have the power to direct NHS foundation trusts to:
- enter into arrangements to consider and/or to prepare for a merger or acquisition with an NHS trust or another NHS foundation trust;
 - merge with an NHS trust or another NHS foundation trust; and
 - be acquired by another NHS foundation trust.
36. It is important to note that a merger of this kind brings about a change in the organisation that is accountable for providing local NHS healthcare services. This is distinct from any changes in how those local healthcare services themselves are organised. Decisions on any service changes remain a matter for local commissioners and providers and remain subject to a number of stringent tests, including strong patient engagement, preservation of patient choice, a clear clinical benefit and support from local clinical commissioners.

Improving planning of capital spending

37. The NHS Long Term Plan sets 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, 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.
38. 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 and the NHS, there are no mechanisms to set capital spending 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 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. And it increases the risk that the Department and the NHS collectively could exceed the limits prescribed by Parliament.

39. **We are proposing that NHS Improvement should have powers to set annual capital spending limits for NHS foundation trusts, in the same way that it can currently do for NHS trusts**, in order to avoid NHS trusts being disadvantaged.
40. We recognise that the ability of foundation trusts to build up funding reserves (or in principle to borrow money, though in practice this is a much less used freedom) to allow additional capital investment is regarded as a helpful freedom, and we would want to avoid – where possible – cutting across these freedoms. The power to set annual spending limits would need to be exercised carefully and would not ultimately prevent foundation trusts from using funding reserves to support capital investment but would mean that they agree with NHS Improvement, working closely with local health systems, when to make large capital investments that might otherwise force other organisations to constrain high-priority investments or increase the risk of breaching the NHS’s overall capital expenditure limits.
41. We intend to work closely with NHS Providers and other stakeholders in designing the detail of the provisions in this section.

6. Every part of the NHS working together

42. We want NHS organisations to work with each other – and with primary care networks, local government and other community partners – as ICSs to jointly plan and improve the way care is delivered. It is only through cross-organisational collaboration that providers and commissioners will be able to use their combined resources more effectively to improve quality of care and health outcomes and reduce inequalities.
43. Establishing ICSs as distinct, new organisational entities would involve a complex reassignment of functions that currently sit with CCGs and trusts. Instead, we believe there are a set of relatively straightforward changes to primary legislation which would remove barriers to collaboration and joint decision-making by letting trusts and CCGs exercise some functions, and make some decisions, jointly. This would be simpler and less expensive than creating new statutory bodies. It would complement the NHS Long Term Plan commitment to have ICS partnership boards that bring together commissioners, trusts, primary care networks, local authorities, the voluntary and community sector and other partners.

Joint committees of CCGs and NHS providers

44. Although current legislation allows CCGs and NHS providers (NHS trusts and foundation trusts) to work together informally, there are no powers for CCGs and NHS providers to set up joint committees to take joint decisions in the interests of their local population.
45. **We propose that organisations should be given the ability to create these joint committees.** The new joint commissioner/provider committees would not do away with the existing responsibilities of CCGs and NHS providers. However, they would provide a mechanism for collective decision-making to agree local healthcare priorities and actions to address them and take a system-wide view on making the best use of their collective resources.
46. Taken with our proposals for new shared duties on NHS organisations to act in the wider interests of the health service, enabling CCGs and NHS providers to form committees would support the more efficient and effective functioning of ICSs.
47. The joint committees would be required to act openly and transparently and would need to work in a way that avoids conflicts of interests. For example, commissioners would not be able to delegate to joint committees decisions on purchasing services. **We are therefore seeking new provisions relating to the**

formation and governance of these joint committees and the decisions that could appropriately be delegated to them.

48. In the same way, it would be sensible to allow NHS providers to form their own joint committees (CCGs already have the ability to do so with other commissioners), which could include representation from other bodies such as primary care networks, GP practices or the voluntary sector. These committees could, for instance, bring local care providers together to set up clinical services networks, a single estates strategy or shared IT, HR and pharmacy services.
49. NHS commissioners or providers already have the ability to enter into partnership arrangements with local authorities (under section 75 of the NHS Act 2006), enabling them to establish joint committees and pool budgets across a variety of health functions. With local government, we will look at how existing provisions for joint working between local government and the NHS might be improved in the light of these proposed changes, including the ability for local authorities to be part of joint committees with NHS commissioners and providers, where this is locally agreed by all parties.

CCG governing bodies

50. One way of achieving improved joint working by commissioners and providers would be to remove restrictions that currently apply to certain members of CCG governing bodies.
51. Legislation gives CCGs a large degree of discretion as to the membership of their governing bodies, but – amongst other requirements – specifies that governing bodies must include a registered nurse and a doctor who is not a GP. Legislation further specifies that this nurse and doctor cannot work for a provider with which the CCG has commissioning arrangements.
52. It is inconsistent to allow GPs to sit on governing bodies but prevent the designated nurse and secondary care doctor from working for other local providers. We believe this rule is too limiting for CCGs to plan services effectively. There would be significant benefit from appointing clinicians from local providers to CCG governing bodies, so they can bring knowledge and insights from providing local hospital, community health or mental health services.
53. **We therefore propose that this restriction should be removed so as to allow the designated nurse and secondary care doctor appointed to CCG governing bodies to be clinicians who work for local providers.**

54. We are confident that any conflicts of interest could be managed, in the same way we currently manage conflicts of interest arising from GP membership of governing bodies.

Joint appointments

55. Letting people hold joint roles across organisations is another way to foster joint decision making, enhance local leadership and improve the delivery of integrated care. They can also help to reduce management costs and engender a culture of collective responsibility across organisations.

56. Although it is possible to make joint appointments under the current legislation, organisations often face legal costs in seeking advice on what they can and cannot do, due to the ambiguity in the legislation, and can leave themselves open to challenge in the future for the appointments they make.

57. **We propose that express provision should be made in legislation to enable CCGs and NHS providers to make joint appointments.** Such a change would need to set out how conflicts of interests would be managed. This would help to reduce both unnecessary legal costs attached to making joint appointments, and the risk of subsequent challenge by others.

7. Shared responsibility for the NHS

58. The Acts of Parliament that currently govern the NHS give considerable weight to individual institutions working autonomously to provide or arrange care for specific groups of patients. However, the improvements in quality of care and health outcomes that are set out in the recently published NHS Long Term Plan rely on shared endeavour. Local NHS bodies, as well as local authorities, need to be able to work together to redesign care around the needs of patients and local communities, not services or institutions.
59. At present, NHS bodies are bound, rightly, by strong duties to provide or arrange high quality care and financial stewardship as individual organisations, and they have statutory duties to co-operate with one another when performing their functions. This is not enough on its own, however, to ensure that local health systems plan and deliver care across different organisational boundaries in ways that secure the best possible quality of care and health outcomes for local communities. Despite the duties of co-operation, organisations can still make isolated and disconnected decisions, rather than working together to consider the potential wider impact of organisational decisions on services and financial sustainability both in their local community and with neighbouring health systems. We believe therefore that NHS bodies should have shared responsibility for wider objectives in relation to population health and the use of NHS resources.
60. **We propose that a new shared duty should be introduced that requires those organisations that plan services in a local area (CCGs) and NHS providers of care to promote the ‘triple aim’ of better health for everyone, better care for all patients, and efficient use of NHS resources, both for their local system and for the wider NHS.** The NHS will need to continue to be a full and active partner in Health and Wellbeing Boards.
61. These statutory duties 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.
62. The legal duties that currently apply to various bodies might need to be amended or extended to ensure they are consistent across all organisations and support this triple aim.

8. Planning our services together

63. Under current legislation, responsibility for planning and funding the provision of health services (commissioning) is split across different organisations: CCGs, NHS England and local authorities. This acts as a hindrance to integrating care for patients and making best use of public resources. Public health services (to help prevent ill-health), primary care, hospital care and specialist mental and physical healthcare are organised by different bodies. We want to join up the commissioning of these services but without creating the distraction of major organisational re-structuring.
64. We propose Parliament remove the legal barriers that limit the ability of CCGs, local authorities and NHS England to work together and take decisions jointly.

Joining up commissioning

65. NHS England has responsibility for commissioning a range of services: primary medical care, dental care, pharmaceutical and ophthalmic services, services for armed forces, and health services for prisons and the criminal justice system. We want the planning and funding of these services to be joined up with other local services.
66. An array of provisions already exists to enable CCGs and local government to work closely together to improve the health and wellbeing of their population through joint commissioning and joint provision. However, a number of legal barriers stand in the way of more joined-up NHS commissioning:
- NHS England currently has powers to delegate a range of its functions to CCGs. For example, over 90% of CCGs have delegated responsibility for commissioning primary medical care on behalf of NHS England. However, once NHS England has delegated a function to a CCG, that CCG cannot then enter into formal joint decision-making arrangements for that function with neighbouring CCGs or local government (as this would constitute unlawful 'double delegation').
 - The Secretary of State currently arranges for NHS England to carry out certain public health functions on his behalf – sometimes referred to as 'section 7A' services. These include: national screening for major diseases and immunisation programmes, and sexual assault referral services. Current legislation does not permit NHS England and one or more CCGs to commission these services jointly. This can make it harder for NHS England to take account of local issues. We believe NHS England should be able to work together with CCGs to commission these services. We are not proposing any change to the Secretary of State's responsibilities in respect of

health protection. The NHS Long Term Plan raises the question as to what constitutes the best local arrangements for the commissioning of certain local services. These are out of scope for this document.

- Unless they are formally merged there are limits on the decisions that CCGs can make jointly.

67. To overcome these constraints, **we propose that NHS England should be given the ability to allow groups of CCGs to collaborate to arrange services for their combined populations. We also propose that CCGs should be able to carry out delegated functions, as if they were their own, to avoid the issue of ‘double delegation’, and that groups of CCGs should be able to use joint and lead commissioner arrangements to make decisions and pool funds across all their functions.**

68. This would further empower CCGs to make joint decisions about planning and delivering care. NHS England would keep overall responsibility for these functions, but CCGs would have the freedom to work jointly with other CCGs to promote greater integration of local services. NHS England would be required to consult on any plans to delegate functions to CCGs.

69. Local authorities would continue to have the right to review and scrutinise the health service in their area and, where there is a substantial development or variation, there would continue to be an obligation on NHS bodies or health service providers to consult with the local authority. The NHS and local authorities have extensive freedoms to work together jointly, including joint commissioning and budget pooling where this is locally agreed.

70. **We are also seeking to enable NHS England to jointly commission with CCGs the specific services currently commissioned under the section 7A agreement or to delegate the commissioning of these services to groups of CCGs.**

Specialised services

71. NHS England is responsible for commissioning a range of specialised services. Many of these services form part of care pathways for patients that include services commissioned by CCGs or local authorities. For example, CCGs commission services for patients with kidney disease, NHS England for patients with kidney failure. This split in responsibilities can hinder efforts to organise care around the needs of patients.

72. It also makes it difficult to make decisions in the round based on the balance of investment between prevention of ill-health, care and support for people with

established but stable long-term health problems, and specialist treatment for people with serious complications in their health. We think there is a strong case for enabling CCGs to be more involved in decisions about specialised services and how they can be better integrated with local services. The only formal mechanism currently available is for the Secretary of State to re-designate services as not being within the scope of specialised services. However, this would not be appropriate for many services which need to be planned on a greater population footprint.

73. **We therefore propose that legislation is changed to enable NHS England to enter into formal joint commissioning arrangements with CCGs** including providing the ability to pool budgets.

9. Joined-up national leadership

74. The public see the NHS as an integrated service. Parliament expects the whole of the NHS to work together to make the best use of its collective resources for patients and the public. 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.
75. As the organisations with most responsibility for setting the direction of and overseeing the NHS, NHS Improvement (technically comprising Monitor and the NHS Trust Development Authority) and NHS England are already working closely together to align what they do, provide more joined-up support for local health systems, and establish integrated teams to carry out most of their functions.
76. However, there are limits on how far NHS England and NHS Improvement can work together. For example, there is no provision to formally carry out functions jointly, there are constraints on sharing board members, and they have separate accountability arrangements to the Secretary of State. This causes unhelpful and cumbersome bureaucracy for both organisations.
77. **We propose that NHS England and NHS Improvement should be brought together more closely beyond the limits of the current legislation, whilst clarifying the accountability to Secretary of State and Parliament.** We believe this would enable NHS England and NHS Improvement to go further in:
- speaking with one voice, setting clear, consistent expectations for providers, commissioners and local NHS health systems;
 - developing a single oversight and support framework for the NHS that supports integration and the best use of resources;
 - bringing together national programmes of work and key activities;
 - using their collective resources more efficiently to support local health systems.

78. **We propose that this should be achieved by:**

either

- creating a single organisation which combines all the relevant functions of NHS England and NHS Improvement (including Monitor and the TDA).

or

- leaving the existing bodies as they are, but provide more flexibility to work together, including powers to carry out functions jointly or to delegate or transfer functions to each other, and the flexibility to have non-executive Board members in common.

79. Both options would require changes to primary legislation.

80. At present, there are different legislative arrangements for the accountability between the Secretary of State and each of NHS England, Monitor and the Trust Development Authority. NHS Improvement is made up of the NHS Trust Development Authority, which is a Special Health Authority, and Monitor, which is a non-Departmental public body with a regulatory focus. NHS England is also a non-departmental public body. If a single body were created, accountability would need to be appropriately defined.

81. Other national Arm's Length Bodies (ALBs) play a vital role in supporting the health system. The Health and Social Care Select Committee has recommended that all national ALBs act in a more joined-up way, particularly on priority areas such as prevention of ill-health and workforce education and training. Responsibility for these issues sits in different organisations, specifically Public Health England and Health Education England.

82. **We propose legislative changes to enable wider collaboration between ALBs by establishing new powers for the Secretary of State to transfer, or require delegation of, ALB functions to other ALBs, and create new functions of ALBs.** This provision would require appropriate safeguards.

Next Steps

83. We hope to achieve broad support for these proposals and we want to hear from as many people as possible. A response to this document can be quickly completed by following this link: <https://www.engage.england.nhs.uk/survey/nhs-long-term-plan-legislation/>
84. It is also possible to submit more detailed comments via this link, once the short survey is complete. Or, if you prefer, we would be happy to receive views via e-mail at england.legislation@nhs.net or in writing to:

NHS Legislation Engagement Survey
Quarry House
Quarry Hill
Leeds
West Yorkshire
LS2 7UE

A copy of the survey is attached to this document.

85. Alongside this, we will actively reach out to the NHS through our ongoing discussions on implementing the NHS Long Term Plan and will seek views at targeted events with partner organisations and interested bodies.
86. The engagement process on these proposals will run until 25 April 2019. Once all responses have been received and considered, we will publish a report which sets out the views received and makes firm recommendations for the Secretary of State.

NHS Legislation Survey

Available online here: <https://www.engage.england.nhs.uk/survey/nhs-long-term-plan-legislation/>

[MANDATORY]

Should the law be changed to prioritise integration and collaboration in the NHS through the changes we recommend?

Strongly Disagree Disagree Neutral Agree Strongly Agree

[OPTIONAL]

1. Promoting collaboration

- Do you agree with our proposals to remove the Competition and Markets Authority's functions to review mergers involving NHS foundation trusts?
- Do you agree with our proposals to remove NHS Improvement's powers to enforce competition?
- Do you agree with our proposals to remove the need for contested National Tariff provisions or licence conditions to be referred to the CMA?

Strongly Disagree Disagree Neutral Agree Strongly Agree

2. Getting better value for the NHS

- Do you agree with our proposals 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?

Strongly Disagree Disagree Neutral Agree Strongly Agree

3. Increasing the flexibility of national payment systems

- Do you agree with our proposals to increase the flexibility of the national NHS payments system?

Strongly Disagree Disagree Neutral Agree Strongly Agree

4. Integrating care provision

- Do you agree that it should be possible to establish new NHS trusts to deliver integrated care?

Strongly Disagree Disagree Neutral Agree Strongly Agree

5. Managing the NHS's resources better

- Do you agree that there should be targeted powers to direct mergers or acquisitions involving NHS foundation trusts in specific circumstances where there is clear patient benefit?
- Do you agree that it should be possible to set annual capital spending limits for NHS foundation trusts?

Strongly Disagree Disagree Neutral Agree Strongly Agree

6. Every part of the NHS working together

- Do you agree that CCGs and NHS providers be able to create joint decision-making committees to support integrated care systems (ICSs)?
- Do you agree that the nurse and secondary care doctor on CCG governing bodies be able to come from local providers?
- Do you agree that there should be greater flexibility for CCGs and NHS providers to make joint appointments?

Strongly Disagree Disagree Neutral Agree Strongly Agree

7. Shared responsibility for the NHS

- Do you agree that 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?

Strongly Disagree Disagree Neutral Agree Strongly Agree

8. Planning our services together

- Do you agree that it should be easier for NHS England and CCGs to work together to commission care?

Strongly Disagree Disagree Neutral Agree Strongly Agree

9. Joined-up national leadership

- Which of these options to join up national leadership do you prefer?
 - combine NHS England and NHS Improvement
 - provide flexibility for NHS England and NHS Improvement to work more closely together
 - neither of the above
- Do you agree that the Secretary of State should have power to transfer, or require delegation of, ALB functions to other ALBs, and create new functions of ALBs, with appropriate safeguards

Strongly Disagree Disagree Neutral Agree Strongly Agree

Neutral

Neutral

Neutral

Strongly Disagree Disagree Neutral Agree Strongly Agree

**[Optional]
Detailed comments**

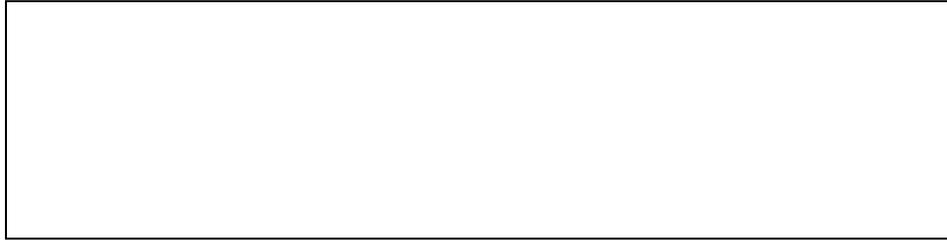
If you have any specific comments or additional information to provide, please provide in the relevant text box.

- 1. Promoting collaboration.** This includes the following proposals:
- a. Remove the Competition and Markets Authority (CMA) function to review mergers involving NHS foundation trusts
 - b. Remove NHS Improvement's competition powers and its general duty to prevent anti-competitive behaviour
 - c. Remove the need for NHS Improvement to refer contested licence conditions or National Tariff provisions to the CMA

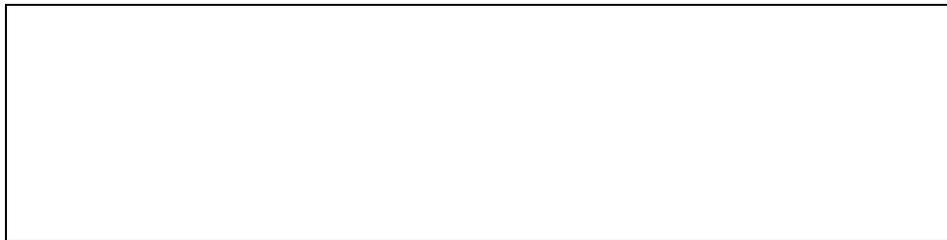
- 2. Getting better value for the NHS.** This includes the following proposals:
- a. Revoke regulations made under section 75 of the Health and Social Care Act 2012 and repeal powers in primary legislation under which they are made, subject to a new best value test
 - b. Remove arrangements between NHS commissioners and NHS providers from the scope of the Public Contracts Regulations, subject to a new best value test

- 3. Increasing the flexibility of national NHS payment systems.** This includes the following proposals:
- a. Remove the power to apply to NHS Improvement to make local modifications to tariff prices, once ICSs are fully developed
 - b. Enable the national tariff to include prices for 'section 7A' public health services
 - c. Enable national prices to be set as a formula rather than a fixed value, so prices can reflect local factors
 - d. Enable national prices to be applied only in specified circumstances
 - e. Enable selected adjustments to tariff provisions to be made within a tariff period (subject to consultation)

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



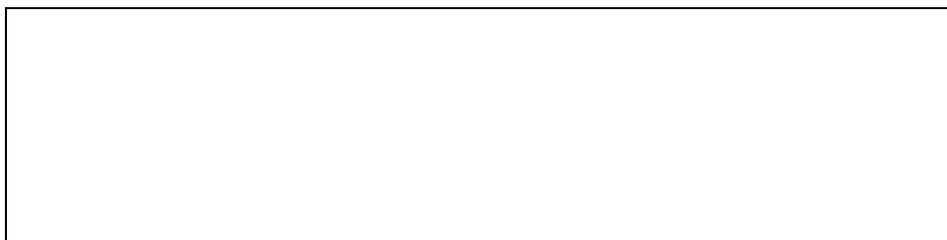
5. **Managing the NHS's resources better.** This includes the following proposals:
- a. Give NHS Improvement targeted powers to direct mergers involving NHS foundation trusts, in specific circumstances only, where there are clear patient benefits
 - b. Give NHS Improvement powers to set annual capital spending limits for NHS foundation trusts



6. **Every part of the NHS working together.** This includes the following proposals:
- a. Enable CCGs and NHS providers to create joint committees
 - b. Give NHS England powers to set guidance on the formation and governance of joint committees and the decisions that could appropriately be delegated to them
 - c. Allow the designated nurse and secondary care doctor appointed to CCG governing bodies to be clinicians who work for local providers
 - d. Enable CCGs and NHS providers to make joint appointments



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



- 8. Planning our services together.** This includes the following proposals:
- a. Enable groups of CCGs to collaborate to arrange services for their combined populations
 - b. Allow CCGs to carry out delegated functions, as if they were their own, to avoid the issue of 'double delegation'
 - c. Enable groups of CCGs to use joint and lead commissioner arrangements to make decisions and pool funds across all their functions
 - d. Enable NHS England to jointly commission with CCGs the specific services currently commissioned under the section 7A agreement, or to delegate the commissioning of these services to groups of CCGs
 - e. Enable NHS England to enter into formal joint commissioning arrangements with CCGs for specialised services

- 9. Joined up national leadership.** This includes the following proposals:
- a. Bring NHS England and NHS Improvement together more closely, either by combining the organisations or providing more flexibility for them to work closely together
 - b. Enable wider collaboration between ALBs

Beyond what you've outlined above, are there any aspects of this engagement document you feel have an impact on equality considerations?

Other comments?

Name.....

In what capacity are you responding? [Please tick]

- Academic institute []
- Charity, patient representative organisation or voluntary organisation []
- Clinical Commissioning Group []
- Clinician []
- Commercial organisation []
- Family member, friend or carer of patient []
- General Practitioner []
- Healthcare professional []
- ICS/STP representative []
- Independent provider organisation []
- Industry body []
- Local authority []
- Member of the public []
- NHS foundation trust []
- NHS national body []
- NHS non-clinical staff []
- NHS trust []
- Patient []
- Professional representative body []
- Regulator []
- Think tank []
- Trade Union []

- Other [Please specify]..... []

Are you responding on behalf of an organisation? Y [] / N []

Organisation name.....

Email.....