Implementing the NHS long term plan: proposals for possible changes to legislation

Response to engagement document

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

Our response below is informed by extensive engagement with senior leaders within NHS providers. Following the publication of the legislative proposals we have sought feedback from trusts through two surveys and an open invitation to comment, receiving around 90 responses. We have held three roundtables with board-level representatives (one of which included input from NHS England and NHS Improvement colleagues).

Key messages

- We welcome and support the national policy direction to develop collaborative working within integrated local health and care systems. We also acknowledge that the current NHS legislative and regulatory framework does not fully support this direction of travel. We recognise that a complete re-write of the current legislative framework has not, at this point, been judged either feasible or desirable. Therefore we need to consider whether a set of carefully drafted and targeted legislative changes can help speed up a move to integrated care. In our view, any proposed set of changes needs to pass the following tests:
    - It must have been fully scrutinised, including extensive consultation and collaboration with the NHS frontline, with careful consideration of any unintended consequences.
    - It must, demonstrably, be better than the alternative options, that is, using the existing legislative framework to drive the required integration and/or waiting for the time when we can recast the NHS legislative framework more radically in support of system working. It is important to note how much can be achieved to support local collaboration and the integration of services within the existing legislative framework.
    - Given that the proposed approach seeks to amend the current legislative framework in places, it must create a clear and coherent legislative framework for NHS organisations to work within, underpinned by a strong commitment to good governance and clear lines of accountability.

- We broadly support a number of the individual proposals made by NHS England (NHSE) and NHS Improvement (NHSI), but it is also important to consider the cumulative impact of the proposals, which we believe would be significant. In particular, in addition to seeking to enable greater local health and care integration, the proposals also seem likely to significantly shift the balance of power between local health and care delivery organisations and the national arm's length bodies. We are concerned that this could negatively impact the local leadership, autonomy, innovation and accountability that are essential for the effective delivery of local health and care services.

- The current legislative framework within the NHS is based on the principle that NHS providers' unitary boards are accountable for everything that happens within their trust. Evidence from the private and public sectors suggests that unitary boards provide the best vehicle for good corporate governance because they combine an independent perspective with detailed knowledge of the organisation in setting strategy and culture, in oversight of the work of the executive and in being accountable to stakeholders, including staff, patients and the public.[1] The fact that the unitary board is responsible and accountable for everything that happens within the trust brings vital clarity in an environment in which service delivery is inevitably often high risk. Whilst we support the need to enable greater system working, we are concerned that some of these proposals would cut across the centrality of unitary boards, potentially blurring accountability and increasing the chance of governance failure. Given that individual boards can, and do, choose to collaborate, the principles of provider autonomy and accountability are perfectly compatible with system working.

- We strongly welcome the discussions we have had with NHSE/I on these proposals and look forward to ongoing constructive engagement with them. We hope that the proposals will now go through the usual and proper channels for legislative development. It may be that, following reflection on responses to the current engagement document, a white paper is warranted before the proposals are developed as a draft bill and further scrutinised by a public bill committee. While the changes are in some ways focused on amending technical details within the NHS' structures and ways of working, they nevertheless would have a significant effect on the spirit and letter of existing legislation and on the public's understanding of how the NHS operates.

Detailed comments

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

On 1a, removing the CMA function to review mergers involving NHS foundation trusts:

A number of providers have been seeking to undertake mergers or acquisitions to address workforce challenges, enable better patterns of service delivery and drive efficiencies. Yet in its involvement in NHS mergers, the Competition and Markets Authority (CMA) has a mixed track record. Its approach, especially in the years immediately after the Health and Social Care Act 2012 (the 2012 Act) was passed, was

[1] See NHS Providers, We need to talk about boards (https://nhsproviders.org/media/1057/we-need-to-talk-about-boards-boards-leadership-and-the-nhs.pdf), July 2015, for further detail.

excessively focused on competition and paid inadequate attention to the public and patient benefit of any proposed transaction. Trusts have found the CMA in many cases to add unnecessary duplication, cost and complexity into the transaction process. Equally though, trusts do note that CMA oversight through the existing process does encourage thorough testing of the benefits of a proposed merger.

We would therefore welcome a review of its role here to ensure an appropriate mergers and acquisitions regime exists within the NHS. Whether the CMA's role is revised or removed, we believe that any future NHS mergers framework should be predicated on a public and patient benefit test with an appropriately robust business case.

There is also significant potential for unintended consequences in changing the role of competition within the NHS, and we would suggest careful consideration as to whether its outright removal is the best option. the following considerations were flagged within our engagement work with providers:

- At present as we understand it, a CMA ruling on a merger can mean that the transaction cannot be challenged under current EU procurement rules. If the UK cannot or does not revise its procurement regime at the same time as changing the CMA's role here, there may be a risk of mergers being challenged as anti-competitive by external bodies.

- We would also note that the NHS is currently predicated on a quasi-market and competitive basis, and while elements of this are being reduced, no alternative conceptual framework has been set out. This may lead to conflicting interpretations of the intent of NHS legislation in the future, and also raises questions around how to ensure patient choice. We believe this would benefit from further consideration.

Finally, this proposal must be seen in combination with that of giving NHSI powers to direct foundation trust (FT) mergers, about which we are very concerned. This would give the national NHS bodies significant powers over local organisational configuration – even though their view may well be out of step with local needs – and trusts would need some recourse in this eventuality. The reduction of competition set out by these proposals would also have an effect on the role of FTs, reducing their autonomy and the value and innovation generated by that freedom. FTs can both maintain their autonomy and collaborate closely with their local systems – these are not mutually exclusive approaches, and in fact create a helpful balance between the sustainability of the institution directly responsible for delivering care and the wider strategic direction of the NHS.

On 1b, removing NHSI's competition powers and general duty to prevent anti-competitive behaviour:

Please see our responses to 1a and 5a – while we are supportive in principle, we have concerns here about unintended consequences and the implications of the combined proposals to remove NHSI's competitive duties and to allow powers of direction over mergers.

On 1c, removing the need for NHS Improvement to refer contested licence conditions or national tariff provisions to the CMA:

We are concerned by this proposal, in respect of both licence terms and tariff provisions. It also needs to be read in light of other proposals, including the merger of NHSE and NHSI; the removal of NHSI's role in local modifications; and changes to the tariff setting process. In combination, these proposals would seem to put trusts at risk of facing a tariff which is financially unviable but unchallengeable, locally or nationally. Likewise, it puts providers at risk of unreasonable licence conditions being imposed.

At present, the tariff is set through the creative tension of NHSE representing commissioners and NHSI representing providers, with the CMA as a route of recourse for the provider (and CCG) sector in the event that nationally agreed prices fail to realistically reflect the cost of activity. If the tension between NHSE and NHSI in setting the tariff is eliminated, and the CMA removed, we need to be mindful that this will have a profound effect on the nationally led process to determine the tariff.

There is good reason for the CMA to hold a "backstop" role here, and these proposed changes therefore need further careful consideration. A decade of austerity, even where there was a split between NHSE and NHSI/Monitor saw the efficiency factor used as the balancing figure within the tariff and a persistent sector deficit has been the result. It is worth remembering the scale of disagreement between the provider sector and NHSE/I on the framing of the tariff in 2015/16 when providers triggered the formal tariff objection mechanism. More recently, the consultation process on the tariff has been disappointing, with minimal opportunity to properly engage on the proposals. Already, the approach taken by the national bodies should be considerably more focused than it is on meaningful engagement with the sector.

This proposal needs to work in both the good times and the bad, and have inbuilt mechanisms to voice challenge when the system is in danger of being unsustainable. We would welcome reassurances about how national decisions could be challenged and scrutinised in the absence of the previous, deliberate checks and balances built into the system given the different roles of NHSE and NHSI.

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

Trusts will welcome a reduction in the burden of tendering created by the procurement rules. 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.

Community and mental health trusts would particularly welcome this proposal as commissioners frequently go out to tender competitively for many of their services. In the community sector, there is significant competition from the independent sector and there is a view that contracts are sometimes won on cost savings, rather than with full considerations of the potential to improve quality of care.

However, we also note that CCGs currently have considerable latitude in determining when to tender, but concerns about legal challenge have tended to make commissioners, understandably, risk averse. CCGs would benefit from clear national guidance on the appropriate implementation of the current regime to ensure its even-handed and proportionate application with quality of care at its foundation. We would encourage NHSE/I to develop guidance on the existing procurement regime alongside its pursuit of these proposals, given the uncertainty around the extent to which the UK will be able to change its procurement rules.

In developing this proposal, it is important to recognise the time it has taken to embed best value duties within local government, and the ongoing competition requirements therein, as well as the need to learn those lessons if a similar approach is adopted within the NHS. We would welcome clarification of issues including:

- How the best value test will be defined

- What the other "key tests" referenced in the engagement document may be
- What process towards contract award would be undertaken and what principles (for example, of transparency) would be applied
- What balance can meaningfully be struck between reducing the administrative burden on providers and ensuring safeguards to ensure contracts are not inappropriately awarded
- How the proposals interact with the range of suppliers of NHS services, such as community interest companies as well as private providers
- How to ensure that NHS community and mental health providers are treated appropriately within the revised rules, given that guidance could treat the sectors differently and leave those that should benefit from greater certainty and less bureaucracy more exposed
- How procurement by local authorities might be affected and aligned
- The range of scenarios that might arise given the uncertainty around the UK's exit from the EU

We appreciate NHSE/I's early engagement with NHS Providers and other key stakeholders on this issue, and also look forward to learning from the approach undertaken within local government.

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)

On 3a, removing the power to apply to NHS Improvement to make local modifications to tariff prices, once ICSs are fully developed

The prices paid by commissioners to NHS providers for the treatments they provide are set by a national tariff with the opportunity for local providers and commissioners to agree local modifications. These prices are fundamental to the successful operation of the NHS as a whole and the financial stability of individual providers and CCGs. Local price modification is a matter for complex and difficult negotiation between providers and commissioners. There are often disagreements, and NHSI has an important role to play in helping resolve these and make those local modifications.

Providers recognise that when ICSs are fully formed, the need for NHSI to make local price modifications should become less necessary. However, the statutory bodies comprising ICSs will still be separate organisations. We should therefore be realistic about the potential for disputes and conflicts of interest. Moreover, neither the national tariff nor the overall funding envelope for the NHS will ever be perfect. There will likely be some occasions where a trust or system faces a structural deficit and needs recourse to the national bodies to help correct that with additional resources.

As ICSs are not themselves statutory bodies, there is therefore a good argument for retention of NHSI's power of intervention on local price modification, both while the journey to integrated local systems is in train and beyond that.

We would however encourage the national bodies to undertake further non-legislative steps to support the ambition of local determination. These include supporting local systems in developing appropriate

risk and gain share agreements to align incentives, helping to align contractual frameworks, and being clear on the appropriate role of ICSs within price modifications.

On 3b, enabling the national tariff to include prices for 'section 7A' public health services

This seems appropriate to us. Further consideration of those services commissioned by local authorities may also be warranted.

On 3c, enabling national prices to be set as a formula rather than a fixed value, so prices can reflect local factors; 3d, enabling national prices to be applied only in specified circumstances; and 3e, enabling selected adjustments to tariff provisions to be made within a tariff period (subject to consultation):

It is first important to look at these proposals in combination with the merger of NHSE and NHSI, we have additional concerns about the fundamental approach taken to financial flows through the NHS. The tariff has, up to now, been set through explicit negotiation and agreement between NHS England (legally, the NHS Commissioning Board) and NHS Improvement (legally, Monitor and the Trust Development Authority), embodying the purchaser/provider split at a national level. The central importance of the national tariff to the successful operation of trusts and CCGs was recognised in the 2012 Act by giving those organisations the right to vote on the tariff each time it was set and the creation of the option of referral to the CMA in the event of disagreement. We recognise that there are benefits of effectively dissolving the purchaser/provider split at a national level by bringing NHSE and NHSI together to operate as a single body. However, providers are concerned that this removes what has, in some cases, been a valuable tension, creating balance within the system and ensuring that the differing commissioning and provision viewpoints are fully represented when key decisions are made on how risk and resources are managed in the NHS.

In response to this proposal, some trusts noted that prices need to vary according to local circumstances, but equally that national prices had helped to reduce disputes between commissioners and providers. Providers also highlighted the risk they faced in having terms imposed on them by commissioners and negotiating with multiple commissioners, questions over the source data and design of a tariff formula, as well as citing the need for transparency and simplicity in the relationship between local prices and national ones. Thought also needs to be given to potential unintended consequences. For example, price differentials may lead to increased out of area flows, a low tariff would not incentivise or reimburse innovation, and there may be workforce implications, with the risk that a low local tariff squeezes pay and makes it harder to attract and retain the right staff.

It is also worth noting that the tariff payment system has undergone significant review in 2019/20 to align incentives between commissioners and providers, with some changes that trusts support and others that they are disappointed by. Wider questions over the suitability of the tariff and the payment by results system also endure, and the tariff at present does not consistently reflect the cost of activity.

There is a careful balance to establish here, and at present there is too little detail and context around these proposals to have confidence. Overall, we would encourage NHSE/I to continue to engage widely on these proposals and the payment system as a whole.

4. INTEGRATING CARE PROVISION. Enable the Secretary of State to set up new NHS trusts to provide integrated care.

We welcome the clear policy expectation that local health and care organisations should collaborate to make best use of public funding and accelerate the integration of services for patients. This drive for

integration is progressing at pace and the system is clearly in transition, with providers and other organisations in the health sector facing a number of operational, financial and governance challenges when choosing how to develop a local health and care system that works for the populations they serve.

At present there is no vehicle to set up new trusts easily, whether integrated or not: new NHS foundation trusts cannot be established from scratch and the 2012 Act did not envisage the creation of new NHS trusts. While we welcome NHSE/I's aspiration to support more integrated models of delivery, the proposal to give the secretary of state powers to create new integrated care trusts raises a number of questions.

Trusts and their local partners can already collaborate and integrate services within the existing legal frameworks. Some have agreed to move forward with structural change – for example, both the Royal Wolverhampton NHS Trust and Northumbria Healthcare NHS Foundation Trust are two of a number of trusts that directly support a number of GP practices and employ their staff direct or through a joint venture. Others are pursuing partnership models which allow multidisciplinary teams to co-locate and work together across the boundaries of primary and secondary care, or indeed of the NHS and social care. The new care model vanguard sites are also important positive examples of locally-led integration. This significant level of integration and collaboration has been achieved within the existing legislative framework.

The proposal is described as arising from a situation where local health and care systems wish to bring some services together under the responsibility of a single provider organisation, supported by a single contract and a combined budget, but where the commissioner struggles to identify a suitable organisation to take this forward. This proposal is intended to enable a vehicle for such a contract to be established.

Given the complexity, financial and human resource, and the time taken to set up a new organisation at this scale and with this level of responsibility, it is appropriate to test other legal routes of achieving the same objective. For example, at present, it may be that, through the recently launched integrated care provider (ICP) contract, an NHS trust or foundation trust could effectively act as a 'lead provider' holding the contract overall and working with a range of local partners including public health and primary care. Another approach taken at the moment is for local providers to work under an 'alliance contract' to deliver similar outcomes. Trusts would welcome support in developing these, as well as clarity as to when integrated care trusts might be pursued rather than these existing mechanisms.

However, as NHSE/I recognise, there may not always be a straightforward means of pursing these routes. Some local areas may also see the cultural benefit of closer, structural integration, particularly with regard to bringing primary and secondary care closer together or using a new organisational form.

Therefore, while legislative change may not be strictly necessary, we see its potential to create some helpful flexibility in the system. However, we are also cautious about its detailed framing and implementation, and we would be concerned that the following are properly taken into account:

a. *Good governance arrangements are properly taken into account in designing the model*
Creating a new trust would be a considerable undertaking, and it is important to build on existing organisational models and approaches. As NHS foundation trusts and trusts can already act as integrated care trusts (for instance, delivering acute, community, social care and in some instances primary care), it may be that the simplest and most effective approach would be to enable the creation of new foundation trusts, building in due consideration for local wishes and resources, as well as any changes to board composition (for example, allowing greater flexibility in the size and make up of a board, where currently this is specified in secondary legislation). Moreover, it is

unlikely that foundation trusts would wish to give up the freedoms of that status, and so this may limit take up – conversely, giving an integrated care trust the same freedoms to those of an FT may remove a barrier to its take up. In other words, we would suggest powers are given to create integrated care *foundation trusts.*

b. *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. There is also the risk that, where relationships break down, commissioners attempt to bypass existing providers through the creation of an integrated care trust. Yet the success of the new trust would seem to depend on positive working relationships and we would be concerned that new trusts should not be set up without the support of all partners in the local health economy in question. Moreover, concerns were also raised by trusts that there needs to be protection to ensure NHS leadership of any trust, as without clarification, it seems there is the potential for private provision to dominate an integrated care trust. Finally, as much as they can work closely together, there are often good reasons for trust types remaining separate and maintaining their distinct focus and expertise. We would therefore suggest that the secretary of state should only have and exercise this power where a unanimous local system application is made to create an integrated care trust which sets out the business case for doing so.

c. *There is sensitivity to existing provision and the sustainability of the local system*
The relationship of a new integrated care trust with existing trusts is unclear. Is it likely to incorporate all existing trusts covering the same area? How would it affect those existing trusts which are not incorporated? To what extent would the potential for destabilisation of existing trusts be taken into account? The complexities of the existing system also need to be accounted for. For example, how would provider groups be able to participate, disaggregate or step out of a proposal for an integrated care trust? Equally, how would integrated care trusts interact with their STP or ICS, or with their primary care network? Is there any national ambition towards having one integrated care trust per footprint (excepting ambulance and potentially specialist providers)?

d. *Consideration is given as to how to manage the change locally*
Patient and service user involvement is essential, as are engagement with staff and ensuring protections for existing staff. We would also note the role of governors within an FT, both as a route of local accountability, and in approving significant transactions. Their role, and that of any successor organisations, needs consideration in the transition to a new trust. The transaction – which presumably would effectively be an acquisition of the trust or FT by the integrated care trust – would likewise need to be approved by the relevant trust boards and governors, and provision made for the existing financial considerations.

e. *It is not used as a tool to threaten the existing trusts or foundation trusts in the area*
The proposal raises the question of addressing friction within local systems. For example, there is the possibility that the threat of creation of a new integrated trust – or of the proposed powers to direct mergers and acquisitions – could be used as leverage to get an existing trust to behave in a particular way. Given the necessary accountable autonomy of NHS trusts and foundation trusts, it is part of their duty to satisfy themselves as to the integrity of proposed service provision. With this in mind, we are particularly keen to ensure any new provisions for the creation of new integrated care trusts rest on local consent of all the relevant parties, including commissioners and incumbent trusts. As with any organisational change, there needs to be a robust clinical case, not just a financial one.

f. *Appropriate national support is available*
Creation of a new trust will take considerable local effort and resources. The transition to the new trust will need considerable national support, realistic set up funding, sensitive and appropriate regulation, and potentially funding for double running to ensure minimal impact on patients and service users through the transition period.

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

We welcome the explicit intention within the engagement document to work with NHS Providers and other stakeholders in exploring these proposals.

On 5a, targeted powers to NHS foundation trust direct mergers:

The challenge described in the engagement document is that a range of improvements – relating to service delivery, resource management, standardising approaches, workforce coordination, and shared back office functions – have been sought, with mergers undertaken as a route to achieving them. NHSE/I state that, at times, mergers – and therefore, their intended benefits – have been "frustrated by the reluctance of one local trust to consider such arrangements". NHSE/I therefore propose a power for NHS Improvement to direct mergers involving NHS foundation trusts.

Provider autonomy and accountability in a system-working context

From our engagement with NHSE/I, we welcome their acknowledgement and support of trusts as the appropriate unit of delivery of services. Trust boards have a clear line of sight to the quality of care delivered by their organisation, and equally, clear lines of accountability from that board to the public, commissioners, regulators, parliament and the secretary of state. Placing these principles of autonomy and accountability within a system-working perspective:

- Statutory bodies, such as trusts, cannot be held accountable for decisions they have not taken.
- Local NHS bodies are not islands – they work together, formally and informally, and increasingly as health and care systems – but they do form the unit of accountability for the delivery of services within the NHS.
- The role of national NHS bodies is to set an appropriate national framework, supporting and enabling local bodies as necessary, and holding local bodies to account through proportionate, risk-based regulation.
- Local populations, patients and service users should also be able to hold the NHS to account.

Across England, there exists a network of local NHS bodies, each embedded in their local areas and working to deliver high-quality patient care. As they seek to transform services and better meet 21st century needs, local and national bodies need to work in partnership with a clear strategic intent and within a rational, rules-based framework:

- The national bodies have established the policy intention of increased integration, with local bodies working together to design care that is person- and community-centred and reflects population needs.
- Successful local collaboration in the delivery of care:
  - Depends on goodwill, strong relationships and shared aims

    - Can be enabled or prevented by legislative, regulatory and contractual frameworks
    - Does not depend on organisational structures
    - Is perfectly compatible with organisational autonomy
- In pursuing integrated care delivery, national NHS bodies:
    - Have the ability to provide support and constructive challenge
    - Should work on the basis that they do not have better insight than local NHS bodies into local circumstances

However, the proposed power does not fulfil the above principles. A merger at the behest of a national body would:

- Fundamentally cut across the autonomy of a board and so leave its officers accountable for a decision they have not made
- Go directly against the grain of the policy intent, wherein integration is locally driven
- Likely fail to realise the intended patient and/or financial benefits as any case made against the merger will still exist

This proposal is therefore a disproportionate and misdirected approach, with it remaining unclear that the power described will fulfil its stated intentions.

Considerations in pursuing a merger

This proposal seems to imply that mergers would be the preferable route to achieving a range of benefits such as efficiencies, standardisation of quality, and access to a more flexible workforce. However each of these benefits can be realised through alternative routes to merger. For example, groups may be formed, workforce "passports" developed to enable staff to operate on different sites and across employers, partnerships formed in particular areas, and peer review and collaboration pursued. Although a merger can be the right pathway for some trusts, it present significant risks, including the potential to destabilise finances, access to services and the workforce. Mergers require significant investment in change management and leadership to align two organisational cultures.

According to a King's Fund review of NHS mergers and acquisitions in 2015, there are disadvantages to creating larger, more complex organisations with conflicting cultures or business models. It concluded that mergers are often "time-consuming, costly and risky transactions" for failing providers which are often based on "faulty argumentation", and which happen without evidence that the root causes of difficulties will be addressed. The review also raised questions around whether the system had appropriate checks and balances.

Mergers can produce substantial quality and financial improvements, and NHS organisations will need to evolve in the coming years – whether they are created, dissolved or merged – in order to best meet population health and care needs. But they are not to be undertaken lightly. These are significant transactions, involving considerable risks, costs and management time.

The risk of misuse of this power should also be considered. One trust may be in deficit and another in surplus, and so to balance this and create a breakeven position, a merger may be encouraged by the national bodies. This ignores a potential structural financial deficit in the local system which will not be rectified through a merger. Whatever the cause of the deficit, its existence and its management will create a drag on the merged organisation. It would be better to address the cause of the deficit directly rather than attempt to hide it. It is also a concern that this power is proposed alongside the removal of the CMA's role in reviewing mergers, such that the trust subjected to the power would have no recourse to an independent body. Similarly, and especially in the context of a proposed merger of NHSE and NHSI, this

means that the national commissioner-regulator would have a significant influence over local strategic plans, presenting a significant conflict of interest and accountability.

An alternative approach

We would therefore suggest that instead of the current proposal, the following principles – respectful of autonomy, accountability and the intention of collaboration – should be adopted:

- A stable and sustainable system is predicated on a mature local-national relationship which respects appropriate autonomy and lines of accountability, and pursues good governance.
- Structure is not in itself a barrier to integration. The national bodies have an important role to play in oversight and facilitating appropriate approaches to correcting a care deficit or pursing care improvements. They can also help to create the conditions for collaboration, as well as empowering local systems to mobilise where one partner is not sustainable.
- Mergers should only be undertaken where there are willing partners with a clear, robust and locally-driven business case predicated on patient, not simply financial, need. The support of staff and local communities is also recognised as vital. Mergers should not be forced by the national bodies.
- Attention should also be given to how the merger process and subsequent transition period will be managed. A merger does not end on the day of the transaction – there must be follow through on the intended benefits.

Therefore, in terms of the approach to take, we suggest:

- NHSI 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 the trusts in the system concerned
    - 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 to enhance this power in this respect)
    - In extremis, NHSI exercising its powers to remove and replace board directors
- 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?
    - As separately proposed by NHSE/I, how should the CMA's role in reviewing NHS mergers be revised?

- Especially in the event that the CMA's role be removed, what assurance gateways for mergers will NHSI put in place?

As one trust told us, "There are inevitable tensions in the NHS. The challenge with a mega-organisation is to get the elephant to dance. So while we need central direction, we also need a lot of independence … These contradictory pressures require oversight – but the style should be more about encouragement than punitive policing". NHSI's starting position should not be for or against mergers and acquisitions: it should promote them where there is a sound need, discourage them where they would be undesirable, and throughout act in the patient interest as facilitator, arbiter and regulator as appropriate.

On 5b, powers to set annual capital spending limits for NHS foundation trusts:

This proposal is intended to address the tension between parliament setting an annual limit for capital expenditure (the CDEL) and foundation trusts rightly having freedom over their capital spending. It is possible that this inbuilt tension could lead to the limit being breached. We recognise this issue and the importance of addressing it. However, as set out below, the proposed approach of creating a new power for the national bodies to set FT spending limits would have significant adverse consequences, and we believe the underlying issue could be addressed in more proportionate and appropriate manner. In short, this isn't the right solution, because the right problem isn't being addressed.

The fundamental importance of board autonomy and accountability in capital investment

Capital maintenance and investment are key elements of frontline service delivery. Providers need to be able to invest appropriately in their estates and equipment to ensure the safety of their service. This proposal fundamentally cuts across provider autonomy and accountability. It is not clear under what circumstances NHSI would be better placed to make a decision about capital investment in local services than the trust board, especially given that the consequences for under-investment will sit squarely with the trust and its 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.

In our survey, several FTs pointed out that one of the reasons for their success is an understanding amongst staff, including clinicians, that efficiency creates funding for investment. Without that, it is harder to motivate teams to innovate and improve. A clear concern came from the survey that FTs would be dis-incentivised from saving and building surpluses. For example, one FT described how it has "pursued a policy in recent years of building up cash surpluses to fund a much needed and significant upgrade of its IT systems. Such investments are complex and difficult to balance value with exact timeframes of spend". The same FT also noted, as did others, that "taking away this independence encourages short term decision making (e.g. using revenue funds to lease items at a more expensive rate due to constrained capital or, when a capital programme hits in year delays, spending the money on something lower down the priority list to ensure it is not lost rather than just delaying the spend)".

What's more, the engagement document describes how the proposal would bring FTs and trusts in line with one another – but arguably the anomaly in the current system is, in fact, the power over NHS trust capital investment, not the absence of that power over NHS foundation trusts. For example, one provider group comprising both FTs and trusts highlighted the impact of those differing statuses: strong governance processes at the FT mean that it has been able to "make the right decisions according to local need" with FT freedoms enabling "developments which meet patients' needs and which have been delivered in a timely manner", while for trusts in the group the "capital approvals process adds delay and cost".

Identifying the issues to address

We recognise the importance of managing the tension between parliament approving an annual financial envelope for capital expenditure across the Department of Health and Social Care (DHSC) and the NHS, and the autonomy that FTs (rightly) have over their capital spending. However, this tension has been managed for 15 years, since the inception of FTs, and we do not agree with NHSE/I that this tension has increased recently because of poor financial forecasting on the part of FTs. This misconception means that an inappropriate solution with significant unintended consequences has been put forward.

Instead, the following are the issues to address in ensuring that the CDEL limit is not breached:

1. The CDEL limit is too low. It has been lowered in recent years, alongside capital to revenue funding switches. While not a problem historically, the CDEL is now too low for the NHS' capital investment needs. The growing capital maintenance backlog is a clear symptom of this.

2. The NHS capital regime – that is, the capital bidding, prioritisation, allocation and approvals process – is inadequate. There is widespread agreement that the risk has been elevated by the poor quality and opacity of the capital allocation process operated by NHSE/I and DHSC, which often leads to delays in the business case process and an uncertainty over what providers should prioritise. This makes it very difficult for providers to forecast capital spend accurately. Feedback from providers on the operation of the current regime includes:

    - References to the national bodies creating blockages and delays, being variable in their engagement and at times lacking a joined up approach, for example, with a business case being signed off but not the underpinning loan.
    - Capital funding or guidance often being delayed such that it cannot be fully used.
    - One FT describing how, due to national intervention, it is unable to invest in replacing facilities or keeping its estate fit for purpose despite a sound business case and STP prioritisation, on the basis that "unless the entire STP capital programme is up to scratch then no partners will get funding".
    - Descriptions from various FTs and trusts of additional issues in accessing capital, as even where this might be raised externally, trusts are concerned about the national regulatory reaction (for example, affecting use of resources scores or triggering liquidity metrics by reducing cash balances).
    - The conditions attached to central pots of capital funding periodically awarded to trusts throughout the year. This often includes a "use it or lose it" condition, with an unrealistic deadline, that undermines board planning.

3. The structure of all the FTs and trusts across England working with a single finance team at NHSI has been unworkable. There have been too many interactions for the central NHSI team to manage, exacerbating the issues in the wider regime. In the words of one provider, "Our regulators simply do not have the bandwidth to control everything from above and we currently are getting quite a few mixed messages about being allowed to get on with it versus having our homework marked".

We also recognise that NHSE/I may be concerned to have more control because provider sustainability funding is now available for capital investment, putting further pressure on the CDEL. However, again, this pressure has not come from poor provider forecasting. It has developed as a result of how the national bodies have designed the financial architecture in this regard.

In sum, the proposed approach penalises the frontline for issues not of their making and jeopardises future efficiency savings, while transferring control to the centre without due rigour or accountability or addressing the fundamental problem.

An appropriate alternative approach

The proposed new power is inappropriate and NHS Providers strongly opposes it. We would welcome the opportunity to work with NHSE/I to develop an alternative way forward which recognises their concerns but which properly addresses the root causes of those concerns. Our view is that the following should be tackled:

1. **The right CDEL needs to be set.** A national commitment has already been made that there will be no further capital to revenue transfers. This is welcome, but not in itself sufficient. The CDEL itself needs to be set at an appropriate level.

2. **A proper NHS capital regime needs to be established.** HM Treasury has instructed the NHS to create a proper capital regime. This work is underway and needs to be finalised and implemented. In our contributions to this work, we have called for a more robust capital bidding and prioritisation regime, with a clear set of rules and criteria. Such a system is vital to giving providers the certainty they need and to frame their investments within a set of strategic priorities.

3. **The relationship between providers and their relevant regional director needs to be developed and utilised.** Their close working relationship with providers should bring a better quality of financial discussion and oversight, and will be of critical importance.

More generally, we would encourage greater dialogue and collaboration, and a supportive rather than punitive approach. Several providers were open to engaging with NHSI on capital, and recognised its at times helpful role (for example in securing early access to capital), as well as noting that STPs are not always looking at a sufficiently large scale (particularly affecting specialist and ambulance trusts). Providers also mentioned the current emphasis on investment in acute sector capital investment at the expense of mental health, community, specialist and ambulance trusts. Therefore it would seem that providers would welcome NHSI playing a facilitative and supportive role in capital planning, with the joint regional directors of NHSE/I likewise being supportive in planning capital expenditure where scale demands it.

Furthermore, a number of providers referenced the important role of their STP or ICS in capital planning, especially in small scale schemes. One FT commented that these footprints can create collaborative processes for prioritising capital bids, and "this would seem to be more appropriate than receiving direction from NHS Improvement, as the local system (and the individual trust boards which make up that system), understand the consequences of under-investment and understand what the priorities for the region are with regards to capital expenditure".

Provider freedoms over capital expenditure bring a number of advantages, including the ability to invest in maintaining safe care, driving efficiencies, and ensuring clear accountability. Putting these benefits at risk when the overarching capital system needs reform is a disproportionate response. Instead, a reasonable, predictable, rigorous and sustainable system must be put in place, with provider autonomy and accountability left intact.

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

On 6a, enabling CCGs and NHS providers to create joint committees

In our answer below, we first note the existing approaches that providers and commissioners are undertaking to support joint working, and then look at how these compare in governance and accountability terms to the proposed joint committees. We then set out a number of important considerations for NHSE/I to bear in mind in taking this proposal forward.

Existing approaches to joint working

Trusts are supportive of joined up working, both between them and with commissioners. In responding to our survey, a number commented positively about existing arrangements to develop system working approaches.

Ways of pursuing joint working at the moment include providers and commissioners holding committees-in-common – essentially two individual committees which meet at the same time and in the same place, making sovereign decisions. In some circumstances, committees-in-common can have some or all of the same membership. This approach has been undertaken where relationships are sufficiently strong and aims sufficiently aligned that two boards can seek to coordinate their decision making, albeit with certain areas excluded.

Elsewhere, boards may set up working groups which can only make decisions over which its appointed members have the delegated authority. An organisation cannot be bound by a decision which the member it appoints to the board does not agree with, so decisions can only be made by consensus.

These approaches do take time and consideration to establish, and some may see them as cumbersome or a barrier to agile decision making. However, it should also be recognised that local NHS organisations are creating new ways of working in a high-risk area. Due challenge, time and a robust approach are therefore appropriate. Moreover, as they are relatively new and have not received consistent national support, systems have largely pursued these approaches themselves. This is a welcome sign of their willingness and ability to work together, even in a legislative framework which is clearly in transition and therefore not necessarily permissive in this respect.

The significant benefits of current approaches to coordinated system working are continuing good governance of individual organisations and clear lines of accountability.

The potential role of joint committees

Meanwhile, joint committees may provide another form of structure for integration and collaboration, helping to accelerate system working, with some local partners likely happy to explore this option and seek to pool their sovereignty. In particular, where CCGs themselves merge such that there is typically one per ICS or STP footprint, we can see the advantages of their working closely with a provider to work across a wider geography. The same may be true where trusts form a joint committee. One trust commented that joint committees had the potential to "support creation of a single version of the truth" and "perhaps

lead to fewer 'transactional' conversations, create greater sense of common purpose and mutual assurance".

However, we need to be mindful of the consequences of their differences from existing approaches, and in particular note that:

a. Joint committees can cloud which entity has ultimate power and accountability, potentially setting up rival sources of authority – in the case of providers, the joint committee or the trust board. This becomes particularly important when the joint committee makes decisions with which the unitary trust board might disagree. Given the considerable risk managed by NHS trusts and foundation trusts, and in combination with the lack of clarity over how responsibilities are held, this presents a pressure on collective board responsibility and accountability.

b. Non-executive directors (NEDs) are not mentioned as part of the proposal. Depending on how the joint committee is constituted, the participants in the decision making can be very different from that of a board, diluting the power and effectiveness of a full unitary board. A joint committee is often composed of executive directors and, sometimes, a single non-executive participant or an independent chair. This does not create the balance or challenge of a full complement of NEDs, and is very different, and potentially significantly less robust, from having ultimate decision-making power clearly resting with a full unitary board.

It is already possible for trusts (as opposed to foundation trusts) to establish joint committees and delegate accountabilities. That they do not currently appear to be making use of this ability, and are instead pursuing routes such as committees-in-common, is notable. Providers responding to our survey also referenced the current ambiguity of STP governance, and asked that this is not replicated within joint committees.

Considerations in developing this proposal

As such, we understand the desire both within NHSE/I and locally to create joint committees, especially in absence of creating ICSs and STPs as statutory bodies, but it Is vital that they do not compromise the integrity of existing trust governance. We suggest that if NHSE/I continue to seek to develop this proposal:

- NHSE/I need to recognise that approaches such as committees-in-common and working groups enable both good governance by individual statutory organisations and coordinated decision making between them. As such:
    - The national bodies should welcome these endeavours and support local systems in their creation. This could include greater promotion and expansion of existing support documentation such as November 2018's *Mechanisms for collaboration across health and care systems*; progressing investment in peer support and sector-led learning; and enabling information sharing between organisations that have already progressed coordinated working arrangements.
    - Where statutory bodies remain, their coordination is based on relationships. These take time to develop and benefit from a supportive framework. It would be helpful if the national bodies recognised this and how relationships evolve. For example, a committee-in-common may be a prelude to joint committee.
    - Some systems may see that a committee-in-common, in combination with the ability for joint appointments to be made, may provide a suitably well-governed and coordinated approach that a joint committee is not needed. Given this, NHSE/I need to be robust in testing the benefits of allowing joint committees to be created, given the governance risks they pose.

- In establishing joint committees:
    - Good governance matters. NEDs provide valuable challenge and assure robust decision making. The value of NEDs is recognised – and has been consistently strengthened over time – within the governance codes for the private sector, and we would encourage the same within the NHS. Their role should be maintained within trusts and included within joint committees. It also seems appropriate for NHSE/I to consider their addition to CCGs, with their governing bodies perhaps becoming unitary boards. The closer working of CCGs with trusts seems to imply need for greater equivalence of governance to maximise the potential for constructive but rigorous challenge.
    - Lines of accountability matter. In the worst case scenario, how would a patient be able to pursue any given claim where a provider or commissioner points to a joint committee as the decision making body responsible for the harm described? That committee does not hold accountability, and yet either the provider or commissioner may have been bound to a decision not of their making, and is now answerable for it. Patients may find themselves in a grey area, while the relevant boards may find themselves liable for factors outside their reasonable control. This is an inadequate situation for all concerned and must be properly addressed.
    - The proposal appears to be built around one CCG and one provider. However, there are multiple variations of the commissioner-provider relationship that need to be considered alongside this proposal:
        - Even where an STP or ICS footprint moves towards having "typically" one CCG, many providers are likely to still have multiple commissioners (for example, alongside a CCG, NHSE is the national commissioner for specialist and some public health services, and ambulance and specialist trusts serve multiple footprints).
        - Where a CCG and provider in one system form a joint committee, especially where there is one CCG in a footprint, this may isolate the other providers and give those organisations within the joint committee disproportionate sway within a system.
        - Is it intended that multiple providers could form a joint committee with a single CCG?
        - Where a provider has multiple CCGs, is it appropriate for them to form a joint committee with one of them?
        - Should a CCG seek to form a separate joint committee with each of its providers?
        - How would joint committees between a CCG and a provider interact with an ICS or STP? Does this present another layer of ambiguity within accountability?
    - How will the proposals for joint committees and joint executive appointments interact? For example, if a CCG and a trust pursue both of these options, the trust's NEDs will be significantly outweighed and will find their role diminished, with an attendant loss of robust challenge and assurance within organisations managing significant risk.
    - Where authority is delegated to a committee, the board should always be able to take that authority back. How will this be ensured under this proposal?
    - Although the overall set of proposals seeks to reduce or remove competition from the NHS, certain key aspects of competition nevertheless remain. In particular, that commissioners contract with providers for delivery. If a CCG and a provider create a joint committee, will contract provision be open to challenge?
    - We welcome the acknowledgement in the proposal that the creation of joint committees is a matter for local discretion. Whatever their final form, this remains essential.
    - Realistically, where commissioners and providers are ready to form a joint committee and take on the attendant governance risks, they have effectively become a single organisation in all but name and lines of accountability. If the national bodies wish to pursue joint committees as an approach, arguably they should allow for its logical successful endpoint,

where commissioners and providers do merge, thereby resolving the significant issue of one organisation being subject to another's decisions and accountabilities.

- Elsewhere, relationships in some systems may not be sufficiently advanced that the existing or proposed approaches to coordinated working are appropriate. It may also be that some do not wish to pursue these approaches – as one respondent to our survey commented, "Our success is because of our autonomy as an FT – we have demonstrated we can work across partners including CCGs and other commissioners to deliver our objectives without a joint committee". This should be recognised and allowed for, with appropriate support from and oversight by the national bodies to (a) ensure services meet patient needs, (b) facilitate close working and relationship building, and (c) intervene where patient needs are not being sufficiently met.
- Whatever form of joint working is pursued locally, it may be helpful for this to be done in the context of a duty on all NHS bodies to work together.

We can see that CCGs and providers may wish to form joint committees. However, NHSE/I need to recognise that (1) their design and governance are vitally important if patients and taxpayers are to be assured of clear NHS accountability, and (2) as one provider commented to us, "change moves at the pace of trust", and so these steps must be discretionary, with other approaches to system coordination also supported.

On 6b, giving NHS England powers to set guidance on the formation and governance of joint committees and the decisions that could appropriately be delegated to them

Please see our response to 6a. In addition, given the concerns we raise above, we ask that this guidance undergoes public consultation before publication to ensure the full weight of expertise in good governance is taken into account.

On 6c, allowing the designated nurse and secondary care doctor appointed to CCG governing bodies to be clinicians who work for local providers

We would welcome this as a way of better enabling shared insights between sectors, subject to clear mechanisms for managing conflicts of interest.

On 6d, enabling CCGs and NHS providers to make joint appointments

Many trusts either 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, another is seeking a joint director of urgent care and flow, and another is seeking a joint ICS appointment. Another would like to appoint a joint strategy director (although its CCG is reticent to do so), while another suggested a joint discharge planning team and a joint project management office.

However, it remains to be seen how sustainable joint appointments between CCGs and providers can be, given the potential for conflicts of interest and duties. Clarification of NHSE/I's views here would be welcome, and we would also encourage guidance to cover a range of scenarios, such as where there may be disagreement over the individual's performance or a preference to split the role again, as well as whether a host organisation continues to be needed for a given role. We would also welcome careful consideration as to whether joint appointments are appropriate at director level, and if so, how should these be managed.

Moreover, we would welcome clarification as to the scope of this proposal. Where a CCG has multiple providers, how will its relationships with providers not sharing a joint appointment work? How will those

trusts – particularly specialist and ambulance trusts – which cover areas beyond any given CCG be taken into account? Trusts may also welcome support in making joint appointments with primary care colleagues.

We would also note other means of closer working and sharing of staff. For example, secondments have been undertaken successfully to work on agreed, common projects, and trusts would also value support to enable staff to work better across organisational boundaries.

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

As well as the existing duties to the public set out in NHS legislation, we would note the ongoing common law duty of care placed on providers. However NHS legislation might change further to this proposal, the latter will continue and gives a clear foundation for trusts in their delivery of healthcare.

We are broadly supportive of this proposal as a way of helpfully creating aligned foundations of system working. A number of trusts raised the potential of such an approach as a powerful way of encouraging collaboration and ensuring that NHS organisations sought to and felt able to work with one another as well as local government colleagues. We see particular value in this proposal as giving proportionate regulatory powers to underpin the desired policy direction, while still allowing local systems appropriate freedom in pursuing collaboration as they see fit.

As there are existing duties on trusts to work in the interests of their local communities, we would welcome clarification as to how existing duties will be revised as we are concerned to avoid any duplication or contradiction. We also note the importance of duties being specific and measurable, with clarity around their effect on the statutory bodies to which they will apply.

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

NHS Providers has 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.

On specialised commissioning, while trusts recognise the necessary role of national commissioning, this alone can result in a lack of local 'wrap around' care for patients in receipt of more specialised provision. Trusts also comment that the current fragmentation and risk aversion in national commissioning has meant that the most beneficial new service models haven't always been developed as quickly as they could have been. Moreover, recent pilots to devolve responsibility for mental health specialised commissioning to networks of providers (working with CCGs to ensure locally-based 'wrap around' community care is available) have proven successful. This suggests that providers have a key role to play in helping lead this work. Although trusts therefore broadly see the benefit of better joint working between CCGs and NHSE, it is important to note that most expertise around specialised services actually sits with providers rather than CCGs, so it will remain essential to engage with providers in shaping new service models.

An area not currently covered by the proposals is the relationship of NHS and local authority commissioners. For example, one trust set out the impact of fragmented commissioning across sectors in sexual health services:

> "STI and contraception services are commissioned by local authorities, yet HIV treatment and care services are commissioned by NHS England. Vasectomy services are commissioned by CCGs, and HPV vaccinations for MSM and cervical cytology are commissioned by NHS England. Every time that a sexual health service is procured by a local authority, it risks destabilising the provision of the other services commissioned elsewhere. HIV treatment and care services are particularly affected, as these are often provided by the same provider as the local authority commissioned service, with a number of staff working across the different services. As the services are not jointly commissioned, providers are required to develop complex reciprocal subcontract arrangements for the provision of staff across different contract areas, to prevent services from being destabilised."

While we understand the focus of the proposals is to legislate for the NHS, we cannot ignore that commissioning and delivery of NHS services is interlinked with local government colleagues. The helpful changes NHSE/I are seeking to make in joining up NHS commissioning will only address part of the issue of fragmentation.

We are also mindful of other concurrent changes taking place, particularly the closer working of NHSE and NHSI with the appointment of joint regional directors, and the potential growing role for providers in undertaking tactical commissioning or lead provider roles. In developing these helpful proposals, we therefore ask for:

- Clarity as to how powers would be shared between CCGs, local authorities and NHS England
- Clarity around the expected impact of these proposals on the commissioner-provider relationship at every level
- Providers to be fully consulted and involved as NHS England and CCGs work more closely together to promote service integration
- Equivalent consideration of how to join up NHS and local authority commissioning
- An appropriate role for providers in commissioning

Moreover, we suggest that further reforms to commissioning may be warranted, including:

- Elevating local commissioning to a strategic function. The move to having typically one CCG per ICS or STP will help this, with form better reflecting intended function, but it is not in itself sufficient. There needs to be a greater national drive to improve the quality of local commissioning and support for the strategic role of CCGs. As one trust commented, "commissioners need to have a better understanding of services in order to commission safely". CCGs are often involved in designing care at a level which trusts are better placed to undertake. Meanwhile, CCGs are missing opportunities to add considerable value in strategic planning (in collaboration with providers and local authorities) and assessing quality and outcomes. The national bodies need to give greater support and clearer guidance, as well as properly holding CCGs to account.
- CCGs being a clear point of local accountability. Foundation trust councils of governors were established as a means of local accountability and rooting FTs in their communities. This has given FTs an affinity with local democratic arrangements. However, while CCGs have a lay member to act as a champion for patients and the public, their role is often unclear to the public and CCGs are not consistently transparent. The development of STPs and ICSs has made local accountability further unclear. As the service works to become more integrated, and improve quality of care, CCGs have an important role to play in ensuring that strategic commissioning decisions are meeting patient and service user needs.

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

On 9a, bringing NHS England and NHS Improvement together:
Although NHSE and NHSI are already working increasingly closely, this proposal is still a significant shift in the way the NHS is led at a national level.

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. The increased coordination and consistency we would expect from this proposal are very welcome. Especially alongside recent the appointment of the joint regional directors, we hope this means trusts and their system colleagues can access clear, rapid, consistent and trusted guidance.

However, we should consider carefully mitigating any risks created by this proposal by ensuring the new national and regional structures have access to provider expertise. It is essential that a detailed understanding of providers' governance and accountabilities, the risks they manage, and of the size and nature of the task set for them, continues to be fed into national policy making and to the regulatory frameworks.

There are also some who believe that the formal merger of NHSE/I would create a single organisation that was too large to function effectively and, potentially, represented too great a concentration of power. Greater clarity is needed around these proposals and how NHSE/I would envisage their future relationship with the trust sector, whether they are acting as a single or more aligned entity.

We would also note what we see as critical success factors to this proposal:

- A sustained commitment to positive behaviours and working cultures. The strategic framework for the NHS needs to be co-created, with NHSE/I listening to feedback from the frontline. There needs to be a collaborative approach in establishing the new regional structures, with local NHS bodies having a voice in what would be helpful and desired ways of working. We would expect the joint regional directors to have highly developed skills in values-based leadership and organisational culture, the ability to inspire and motivate others, and to cultivate trust, confidence and respect of key stakeholders. Discussion is also needed as to how ICSs, STPs and regional directors, as well as trusts and commissioners, with primary and social care colleagues as appropriate, will work together and maintain clear lines of accountability.

- A commitment to a supportive, collaborative and respectful relationship with local NHS bodies. As one provider noted, the relationship with NHSE and NHSI has become less arm's length in recent years, "with often too much operational detail sought and too much duplication in the information required", adding that "this does not represent a good use of resource or enable an FT to have the autonomy it deserves whilst it performs well". The same provider notes that, "what has been important and we would want to keep is the level of openness we have always had with our relationship team and their level of constructive challenge and support". The stated policy intent of these proposals is to enable collaboration. This positive approach should be true locally and nationally. NHSE/I need to focus their attention on high-quality commissioning, enabling and regulating local bodies in a proportionate and risk-based manner, and avoid a punitive, burdensome or interfering approach.

- A clear and robust approach to managing the appropriate systemic tension between NHSE and NHSI. The 2012 Act was based on a deliberate tension between NHSE and NHSI. This exists in multiple places, but of particular note is setting the national tariff, where at present both commissioners and providers have a body that in effect represents their interests. We need to think through the consequences of there being a single national organisational structure while the same theoretical framework is left in place at the frontline. Looking more widely, the right single planning, finance and performance framework and process needs to be established as a partnership between commissioners and providers – this needs to be co-produced and based on a proper understanding of what provider leaders can realistically deliver in a constrained financial envelope, rather than becoming an over-ambitious and potentially commissioner-led framework. The powers and responsibilities of the joint NHSE/I regional directors and their teams also need to be clarified, as do steps to ensure a proportionate and consistent approach across England.

  Overall, a system will be created of a national commissioner-regulator. There is a clear conflict of interest inherent here, with the same body that sets the task then judging performance, even though the task itself may be unreasonable. It may be that this conflict is manageable, and that pursuing a supportive oversight role sufficiently reconciles this. But there will be areas where it is helpful for NHSE and NHSI to have continued, separate roles. For example, there are several regulatory areas – such as special measures and setting licence conditions – where a separation will be needed to ensure that providers are not subject to interference by the national commissioner in how their organisations function.

Therefore, we are supportive in principle of this proposal, but how it is achieved and sustained in practice will be critical to its success.

On 9b, enabling wider collaboration between ALBs:

There is a logic for giving the secretary of state greater power to transfer responsibility between ALBs, particularly in light of the evolution of NHS England and NHS Improvement, with the latter's constituent organisations, Monitor and the Trust Development Authority. However, careful analysis of how such a power should or would be used is needed. For example, it would give the secretary of state considerable direct influence on NHS organisation and structures. While some rationalisation of ALBs may be helpful, we must 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.

Between 1974 and 2015, the NHS was reorganised 20 times in 41 years. The creation of STPs in 2016 was arguably a further reorganisation in all but law. As the Institute for Government points out, performance tends to fall in the first two years of major structural reforms. For the NHS to achieve the ambitions set, it needs an extended period of stability in which to embed relationships and ways of working.

10. OTHER COMMENTS?

While we recognise the desire to focus the proposals as narrowly as possible, given the impetus on removing barriers to integration, there do appear to be some lacunae.

Incentives need to be aligned across the NHS, potentially through a combination of legislative, contractual and regulatory means. In our discussions with trusts, a repeated request was for greater alignment of contractual incentives, payment mechanisms and financial flows, of devolving budgets, and of avoiding adverse incentives (such as the inability to move work within the system because of the financial implications).

Additionally, while the proposals include significant focus on trusts and organisational structures, less attention is given to primary care and how it interacts and integrates with the wider sector. Similarly, the proposals are silent on removing barriers to working with local authorities, and whether there are more opportunities to better integrate health and social care. Finally, there remains a question as to how enable regulation, as well as quality inspection led by the Care Quality Commission, which is sensitive to system working.

These gaps perhaps suggest the value of an overarching explanation of how the national NHS bodies see the barriers to integration being overcome, both including and beyond legislation.

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