Legislative proposals for an 'NHS bill'

NHS England and NHS Improvement (NHSE/I) have today published a revised set of legislative proposals for a targeted NHS bill. This briefing sets out how the proposals have developed over the course of 2019 and NHS Providers' engagement, including our influence on the evolution of key proposals on behalf of the provider sector, and a summary of the latest proposals. If you have any comments, or would like to discuss our work on the proposals further, please contact Ferelith Gaze, head of policy and public affairs (ferelith.gaze@nhsproviders.org).

Development of the proposals

In January, the NHS long term plan (the LTP) set out an overview of barriers to collaborative working that NHSE/I would like to address via legislative change. Their legislative proposals were then set out in an engagement document, *Implementing the NHS long term plan: proposals for possible changes to legislation*. NHSE/I's rationale for its legislative change proposals is that successful implementation of the LTP depends "mainly on collective endeavour", and requires local and national NHS bodies to work together to redesign care around patients. For more information on the original proposals, see our on the day briefing: https://nhsproviders.org/media/637441/nhs-providers-briefing-proposals-for-possible-changes-to-legislation.pdf

Drawing on extensive engagement with trusts, NHS Providers' responded to the NHSE/I engagement document and over the summer has taken part in a series of discussions both directly with NHSE/I and as part of a broader stakeholder group to influence the development of the proposals. We have held a number of detailed bilateral meetings with the lead drafters of the proposals at NHSE/I to influence their positioning. We have also engaged with the Department of Health and Social Care (DHSC). The health and social care select committee undertook an inquiry into the proposals (to which NHS Providers gave written and oral evidence), and published its report in June.

NHSE/I, as part of their September board papers, have now published their response to the engagement document and a set of revised proposals for legislative change.

NHS Providers view

We welcome and support the national policy direction to develop collaborative working within integrated local health and care systems. Significant progress can and has been made by developing local relationships, new partnerships and ways of working across sectors. However, 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, it is appropriate to consider whether a set of carefully drafted and targeted legislative changes can help speed up a move to integrated care in local systems.

We broadly supported a number of the individual proposals, but felt that the cumulative impact of the proposals was significant. In particular, in addition to seeking to enable greater local health and care integration, the proposals seemed likely to significantly shift the balance of power between local health and care delivery organisations and the national arm's length bodies. We were 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.

Two issues exemplified our concerns about a potential significant increase in central power at the expense of local decision making: proposals which would give NHSI powers of direction over foundation trust mergers and acquisitions (M&A) and capital spending. Both these proposals would enable NHSI to cut across provider board autonomy and undermine their accountability.

As described above, we have undertaken extensive engagement and influencing work to try to ensure that the proposals were shaped appropriately to work with the existing wider legislative framework and to both support the sector's collaborative direction of travel and respect the continuing board accountability of NHS foundation trusts and trusts. Through this work, we have secured agreement to revise a number of proposals. We would particularly note the following:

1. **Proposal to give NHS Improvement targeted powers to direct mergers involving NHS foundation trusts, in specific circumstances only, where there are clear patient benefits:** This proposal will not now be taken forward. We argued strongly that a merger at the behest of a national body would: (1) fundamentally cut across the autonomy of a board and so leave its officers accountable for a decision they have not made; (2) go directly against the grain of the policy intent, wherein integration is locally driven; and (3) likely fail to realise the intended patient and/or financial benefits as any case made against the merger will still exist. This proposal was therefore a disproportionate and misdirected approach, with a lack of clarity about whether the power described would fulfil its stated intentions. We put forward the alternative approach that, 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 could include questioning whether the trust board is adequately fulfilling its duties and licence conditions and, in extremis, NHSI exercising its powers to remove and replace board directors. We are pleased to see that NHSE/I have agreed with us, and do not now recommend adopting this power.

2. **Proposal to give NHS Improvement powers to set annual capital spending limits for NHS foundation trusts:** This proposal will now be tightly circumscribed. The revised proposal, published 26 September, states that this would be a narrow 'reserve power', which each use of the power limited to one FT, ceasing at the end of the financial year, with NHSE/I being required to

explain why it is necessary to use the power, describe what steps it had taken to avoid requiring its use, and include the response of the FT. To ensure transparency the reasons would be published. The precise form of publication will be a matter for the Bill drafting process, but NHSE/I notes that NHS Providers has stated its preference that publication should be in Parliament.

These restrictions have been secured through NHS Providers' detailed negotiations with NHSE/I. We were faced with a choice of drawing a 'red line' at the prospect of any power, and being asked to withdraw from the national engagement exercise (at which point NHSE/I could have framed the power as liberally as it chose) or continuing to engage constructively and seeking to come up with practical ways to circumscribe the power as far as possible.

Given the importance of this proposal and the likely, and understandable, concern from members about any such power, we checked with the NHS Providers chair and board to secure trustees' views on whether or not we should accept these revisions. While ideally there would be no power, the revised proposal from NHSE/I seems to be the 'least worst realistic option' and a significant improvement on the original proposal. Our board was therefore content that we continued to engage along these lines. We will continue to keep a close watch on how this power is drafted into legislation, but we take the view that it is a significant improvement on the initial unbounded power.

3. Proposal to remove the need for NHS Improvement to refer contested licence conditions or National Tariff provisions to the CMA: Although NHSE/I seemed to imply by this wording that the objection mechanism to contest the tariff would be retained, as we discussed this proposal further I, it became clear that this was not their intention. Through our continued engagement here, they have now agreed to retain the objection mechanism and further discussions will take place as to revised next steps (that is, in the absence of the CMA's role) in the event of the objection mechanism being triggered.

4. Proposal to enable the Secretary of State to set up new NHS trusts to provide integrated care: Originally, as set out in the engagement document, "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". Following our intervention, greater emphasis has been placed on the need for local engagement, including reference to existing providers. Our view of this change is that it may not be strictly necessary, but it has potential to create some helpful flexibility in the system. We are cautious about its detailed framing and implementation, and so in the event of a bill, will seek to work closely with the national bodies on further developing this proposal.

5. Proposal to enable CCGs and NHS providers to create joint committees: Our view is that we can see that CCGs and providers may wish to form joint committees. However, it needs to be recognised that (1) the design and governance of joint committees 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. We therefore emphasised the importance of these committees being voluntary undertakings which cannot be imposed from above, and are pleased to see this reflected in the revised proposals.

There remain a number of areas where further questions remain and we will continue to engage on these through the usual channels as any further consultations and drafting are undertaken. In particular:

- Procurement – further consultation is expected to clarify the scope of changes to procurement rules, and the basis of the new NHS procurement regime.
- Integrated care trust governance – there are a number of restrictions on NHS trust governance at present. How these would be amended to enable ICTs to form and incorporate a wider range of sector colleagues (including primary care for example) is unclear.
- Tariff objection mechanism – the next steps, in the event that the mechanism is triggered, need to be established. How transparency and reporting around tariff and licence decisions would be ensured also needs to be confirmed.
- Tariff setting – NHS Providers raised concerns about the loss of the creative tension between NHSE and NHSI in setting the tariff should they be merged. These concerns have yet to be fully addressed.
- NHSE/I merger – how to ensure that the appropriate powers and responsibilities of NHSE and NHSI were carried through into their combined legislative base needs to be confirmed.
- NHSI's role in local modifications to tariff prices – this depends on the development of ICSs, and it is unclear at what point NHSI's powers here would be revoked.

It is worth noting that all the proposals stem from NHSE/I's recommendations at present, and it is for the government to take them forward, or not. Therefore, we may see further changes and, additionally, there remains significant further detail to work out in the drafting of the bill. For example, the proposals relating to procurement are currently under-developed in part because of lack of certainty over the UK's future relationship with the EU and the extent of changes to procurement and competition law that will be possible. Throughout our conversations with the national bodies, we have therefore reserved the right to continue our influencing work as appropriate during the progress of any subsequent bill.

NHS Providers press statement

NHS Providers welcomes direction of travel set out in targeted NHS legislative proposals

Responding to the recommendations for the NHS Bill published today by NHS England and NHS Improvement, the director of policy and strategy at NHS Providers, Miriam Deakin, said:

"The publication of these proposals follows welcome engagement with the sector from NHS England and NHS Improvement, and we are happy to support the direction of travel.

"Trust leaders support the move to integrated care within local systems, which is central to delivering the NHS long term plan, and, of course, improving services for patients.

"Although collaborative working is entirely possible at the moment, the current legislation has thrown up barriers, delays and difficulties. So it is right that we look carefully at what targeted changes can be made to the law while avoiding a substantial restructure of the NHS – which nobody wants to see.

"We are pleased to see that a number of comments from the provider sector have been taken on board as these proposals have evolved.

"In particular, proposed powers for the national bodies to direct foundation trust mergers and acquisitions have, rightly, been completely removed leaving the autonomy and the accountability of statutory trust boards intact. Although we have concerns over proposed central powers to direct the capital spending of foundation trusts, it is good to see that NHSE/I has listened carefully to our suggestions and that the recommendations for these new proposals are tightly controlled and would only be used once other routes have been exhausted.

"It is also good to see that proposals to create new integrated care trusts must be based around local engagement and that the option of developing joint committees between trusts and CCGs will be voluntary.

"While the proposals put forward are deliberately targeted, and are not intended to completely restructure the NHS, taken together, this could mark a significant change to how the NHS operates in the future. We will continue to work with NHSE/I, the Department of Health and Social Care and parliament if as expected these proposals move forward into the legislative stages."

Summary of the revised proposals, published 26 September

A) Promoting collaboration

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

NHSE/I recommend amending the Health and Social Care Act 2012 (the 2012 Act) so that mergers and acquisitions are not subject to the CMA's merger regime under the Enterprise Act. NHSE/I note overall support for this proposal, although concerns were raised about the potential impact on patient choice, which it proposes to address through legislation to strengthen patient choice requirements (see below). NHS Improvement's power to set licence conditions in relation to choice would also be retained.

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

NHSI would no longer have general competition law powers to enforce the Competition Act 1998, or to conduct market studies or make market investigation references under the Enterprise Act 2002. It would though retain its ability to set licence conditions relating to choice and competition. This would be in order to provide a safeguard against the risk that providers could develop models which are not in patients' interests, although the expectation is that such conditions would rarely be subject to formal enforcement action. Amendments to relevant existing licence conditions may be made to reflect these changes, and new guidance may also be issued.

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

NHSE/I argue that it should be able to make its own decisions about licensing conditions., with accountability arrangements to the Secretary of State and Parliament offering a safeguard against disproportionate changes to licence conditions. NHSE/I would also retain the explicit duty to consult on proposed changes to licence conditions and proposed changes to the tariff. The objection mechanism will be retained, and NHSE/I propose that, if "objection percentage" thresholds are exceeded, it must discuss the issue with representatives of the objectors and publish a response to the objections stating whether it is to: (i) revise the proposals and re-consult; or (ii) retain the current proposals (and in doing so, set out its reasons for proceeding).

B) Getting better value for the NHS

Recommendation 4: Regulations made under section 75 of the Health and Social Care Act 2012 should be revoked and the powers in primary legislation under which they are made should be repealed

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

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

NHSE/I recommend that section 75 of the 2012 Act is repealed and new provisions are made in legislation and statutory guidance which:

- Establishes a new NHS procurement regime under which commissioners of NHS healthcare services must act in the best interests of patients, taxpayers, and the local population when making decisions about arranging healthcare services. They would also have to act in accord with criteria set out in statutory guidance.
- Permits NHS commissioners to make such arrangements at their discretion (that is, without having to undertake a full tendering exercise first unless it would be in the interests of patients, taxpayers and the local population), subject to adherence to related statutory guidance.
- Establishes a power to issue statutory guidance to which NHS commissioners must have regard when making such arrangements with providers.
- Removes the commissioning of NHS healthcare services from the scope of the Public Contracts Regulations 2015. The extent to which this is achievable is contingent on other legislative proposals, as well as broader issues relating to EU law and the UK's future relationship with the EU.

These changes should apply to commissioners when making decisions about healthcare services only. It is not intended that other NHS procurements (such as procurement of pharmaceuticals) are taken out of the scope of PCR.

Recommendation 6 replaces the original proposal that NHS commissioners would be subject to a new "best value duty", and instead refers to a "new NHS procurement regime" on the basis that the former description may be taken to imply that the cost of services would be the predominant consideration in healthcare investment decisions. When the Bill is published, draft proposals elaborating on this regime will be published and a separate consultation will be undertaken. It is important to note in the meantime that:

- NHSE/I accept that some services should never normally be subject to procurement either because the NHS is the only credible provider (e.g. Type 1 A&E) or because providers are contracted at zero guaranteed value through an accreditation process (e.g. for elective choice).
    - NHS Providers would note that this leaves open a significant question around the procurement of community and mental health services, both of which are currently most exposed to burdens here. The status of 111 services is also unclear.
- NHSE/I state that commissioners should always, as now, continue to have the ultimate right to choose to use procurement where they consider this in the best interests of their population, without fear of unnecessary challenge. Where commissioners do so, they should ensure they do so in a way which is compliant with relevant guidance and principles on the use of public funds, such as Treasury Guidance (Managing Public Money), which would be reflected in the new NHS regime.
- NHSE/I intend the new regime to apply when making arrangements with all providers of NHS services, rather than just NHS statutory providers.
- NHSE/I state that the duties would need to be compatible with commissioners' existing duties including public engagement and consultation, management of conflicts of interest, equality, reducing inequality and others. Appropriate scrutiny and oversight mechanisms are needed.
- NHSE/I acknowledges feedback that, in awarding contracts, all aspects of quality (including safety, effectiveness, and experience) were important, as well as patient choice and improving access, tackling inequalities, promoting integration of care, ensuring sustainability of services, value cost and affordability, generating or maintaining social value, and promoting innovation.

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

As part of the changes to procurement policy, NHSE/I is proposing to revoke the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 (the PPCCR) made under section 75 of the 2012 Act. However, NHSE/I propose that the specific choice elements of the PPCCR are maintained. This would be achieved by amending the power in primary legislation to set standing rules to ensure that additional provision is made in relation to protecting and promoting the right to patient choice, and then amending those standing rules to include the provisions on choice currently in the PPCCR. It is also intended that the requirement in regulation 6 of the PPCCR for commissioners to properly manage conflicts of interest when making commissioning decisions would be retained elsewhere in legislation.

Maintaining the choice elements of the PPCCR in the Standing Rules would mean:

- That patients continue to have a legal right to choice for particular services
- That commissioners are still required to offer and facilitate choice to patients, including where appropriate through the use of Any Qualified Provider (AQP) arrangements
- That NHSE/I keep Monitor's powers of investigation and enforcement.

NHSE/I propose that the power to make standing rules (section 6E of the Act) is amended so that:

- It is clear that the Secretary of State can set requirements for the purpose of protecting and promoting choice, not just requirements as to the arrangements they must make to enable patients to make choices (see section 6E(2)(c) of the 2012 Act), and
- It includes specific power to make provision for NHSE to secure compliance with the requirements on CCGs relating to patient choice.

NHSE/I also proposes that legislation is amended so that the standing rules regulations *must* include provisions for patient choice, not simply *may* include (as currently set out in sections 6E and 75 of the 2012 Act). The standing rules would be amended to include the patient choice provisions that would be revoked on repeal of section 75, thereby replicating:

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

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

C) Increasing the flexibility of national NHS payment systems

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

NHSE/I would determine whether any particular price is a fixed amount or a formula, and could provide for all prices to be a fixed amount or for all prices to be a formula. It would also be able to apply different formulae to different services. If specifying a price as a formula, NHSE/I would have to specify the individual elements of that formula.

NHSE/I's aim is to build greater flexibility into the national tariff to enable it to better support system change designed to deliver better quality and more sustainable patient care, rather than to move away from national prices in favour of locally-determined prices. NHSE/I give the example that it would better support implementation of a blended payment approach by enabling payments to be based on national prices and locally agreed activity plans, and that this change would also support multi-year tariffs by enabling future tariffs to be set as current price multiplied by inflation.

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

NHSE/I are currently unable to update prices in-year to reflect, for example, changes in the cost of medicines included in tariffs. It is therefore seeking to be able to amend a national tariff at any point during its period of effect (and be able to make amendments any number of times). NHSE/I would be required to consult with those affected by a proposed change. This power would be limited in that it should not apply where the change is so significant as to require a new national tariff and full consultation exercise.

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

NHSE/I expect that this change would come into effect once ICSs are fully developed as any modifications to tariff prices should be agreed within the ICS and providers and commissioners would still be able to agree local modifications to tariff prices. NHSE/I argue that local modifications are not conducive to integrated working and, once ICSs are fully developed, there should be no reason why providers need to apply to NHS Improvement for a local modification of national prices rather than reach local agreement.

NHS Providers notes that STPs and ICSs are developing in a range of ways and at varying pace, and therefore greater clarity is needed about how and when NHSI's role here would be removed.

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

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

D) Integrated service provision

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

Provisions in the 2012 Act for the abolition of NHS trusts would be revoked, along with the associated required further repeals and amendments. This would confirm the retention of the NHS trust model and the Secretary of State would be able to establish new NHS trusts for the specific purpose of delivering the integrated care provider (ICP) contract (or similar arrangement) without the potential uncertainty if the provisions for abolition remain in place.

Primary legislation would include provision for regulations that would govern how the power to establish new NHS trusts is to be exercised, including the application process. Additional non-statutory guidance may be needed to explain the policy intention around the use of the power to those ICSs considering the ICP model at place level.

Subject to the recommendation to remove NHS commissioning from the scope of the Public Contracts Regulations 2015, non-statutory providers would not be able to hold an ICP contract under this provision.

NHS/I intends to define that the power could only be exercised either:

- Where the trust is to be established for the purpose of securing the provision of integrated care for the population of a particular area or a particular CCG or group of CCGs
- Or only as may be specified in regulations

There would be an application and approvals process set out in regulations for establishing a new trust, and it is envisaged that the procedure would include requirements as to the following:

- The applicant – this would be commissioners wishing to award the ICP contract
- Engagement undertaken and local support
- The rationale – this would set out the strategic business case around the award of an ICP contract and the necessity for/desirability of a new NHS trust to deliver it
- The proposed governance composition for the proposed NHS trust, which should reflect the clinical expertise/specialties/delivery partners required to deliver the relevant ICP contract service scope, and local authority and patient/community representation

NHSE/I state they would also set out specific requirements in regulations as to who should be consulted before a new NHS trust is to be established. This would include:

- Relevant local NHS providers
- Relevant local authorities and their local health and wellbeing boards
- Relevant ICS partnership board (contingent on relevant legislative proposal)
- Local Healthwatch
- Patients and the public
- Key stakeholders and delivery partners including local NHS providers and PCN configurations
- NHS England and NHS Improvement

E) Managing resources efficiently

The original proposals from NHSE/I were to:

- Give targeted powers to NHSI to direct mergers or acquisitions involving NHS foundation trusts in specific circumstances where there are clear patient benefits
- Give NHSI powers to set annual capital spending limits for NHS foundation trusts

Following the strong objections from the sector, and in particular NHS Providers, NHSE/I does not now propose that there should be a specific power to direct foundation trust mergers or acquisitions. Instead, in circumstances where there is a clear direction from the local system for closer working, but where a FT board refuses to cooperate, NHSE/I could consider whether the board is complying with its licence conditions relating to governance and, if appropriate, use its regulatory powers of intervention in response to a suspected breach of those conditions. Consideration could also be given to imposing an additional governance licence condition under section 111, aimed specifically at action required to collaborate with system partners. NHSE/I could, in sufficiently serious cases, use the breach of this additional licence condition as a basis for leadership intervention if needed action was not forthcoming.

Again following sector objections, and following engagement with NHS Providers in particular, NHSE/I have revised their recommendation on powers over FT capital spending.

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

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

F) Every part of the NHS working together

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

NHSE/I recommends introducing specific powers in legislation to allow joint committees of CCGs and NHS providers (NHS trusts and foundation trusts) on a voluntary basis. The legislation should be flexible enough to enable joint committees to operate at regional, system and place levels, and with the option for local authorities to participate where locally agreed. In addition to CCGs, NHS trusts, foundation trusts and local authorities, NHSE/I intends that joint committees may also include primary care networks, voluntary sector organisations and other relevant organisations.

NHSE/I does not intend to change existing accountability arrangements of NHS commissioners and providers, and so each organisation would retain its accountability for its individual actions (including

those determined on its behalf by a joint committee). The membership of joint committees of commissioners and providers should be held to account by their constituent organisations for the decisions made by the committee and the range of oversight and intervention provisions for the constituent organisations of joint committee arrangements continue to apply. The constituent organisations would determine what functions the committee exercises; set out criteria, standards, principles or success measures to apply to how the committee operates; and decide how and when they will review the committee's performance in respect of these.

NHSE/I state that joint committees should ensure transparency and fairness of decision-making and should be required to:

- Make decisions in public meetings
- Minute and make public its discussions and decisions
- Publish papers in advance of meetings
- Maintain a publicly accessible register of members' interests
- Hold an annual general meeting and publish an annual report

Joint committees would be subject to statutory guidance setting out core requirements about governance, use of public funds and addressing conflicts of interest.

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

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

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

NHSE/I proposes consideration is given to whether an explicit power is needed so that NHSE/I issue statutory guidance which could clarify the circumstances in which joint appointments across different organisational types can be made. Given concerns around this recommendation and the difficulty of managing conflicts of interest, NHSE and NHSI would consult on the application of such guidance.

G) Shared responsibility for the NHS

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

NHSE/I recommends that a new 'triple aim' of better health for the whole population, better quality care for all patients and financially sustainable services for the taxpayer should be introduced, as reciprocal

goals for NHS commissioners and providers alike. The NHS improves wellbeing as well as health, and as recommended by the select committee, that goal should be appropriately reflected on the face of the Bill, while being mindful that the term "wellbeing" is currently set out in existing legislation, with requirements that go beyond the abilities of NHS organisations into the wider determinants of health. NHSE/I intend that inclusion of "wellbeing" here should be drafted to avoid placing unrealistic expectations on NHS bodies.

An agreed statement of what is meant by the triple aim may be set out in statutory guidance. NHSE/I sets out its understanding as:

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

NHSE/I proposes that the performance of the Triple Aim Duty will also include a requirement to collaborate with other organisations in order to promote the Triple Aim. The intention is to embed these principles in planning and decision making to reinforce existing duties to engage citizens and patients, to cooperate and to integrate care. The new Triple Aim Duty would be consistent with existing legislation, so when collaborating, regard will need to be had to the rules and requirements around consultation, procurement and engagement before agreement to work together is reached.

Local authorities would not be subject to the Duty directly, unless under contractual arrangements, but would work closely with the NHS in situations where the Triple Aim Duty applies – including through joint commissioning arrangements with the NHS. Each NHS body would need to ensure that the existing NHS and local authority duties on collaboration, population health and wellbeing, and integration, are fully taken into account alongside the new Triple Aim Duty.

The duty would be reflected in provider licence conditions, and NHSE/I would have oversight of the application of the duty by NHS trusts, FTs and CCGs. However, NHSE/I does not propose mandating specific requirements to demonstrate how the Duty has been considered.

H) Planning our services together

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

To facilitate governance arrangements and reduce the risk of challenge to CCG decision-making where joint committees and committees in common meet at the same time and place, NHSE/I proposes to enable groups of CCGs in joint and lead commissioner arrangements to make decisions about and pool funds across all their functions, with a few exceptions. The following CCG functions should continue to be excluded from joint arrangements, so they remain the responsibility of the individual CCG:

- Having a governing body
- Having an audit committee
- Having a remuneration committee
- Applications for variation of constitutions, merger, dissolution etc
- Maintaining a register of interests
- Ability to exercise functions with third parties (individual CCGs should always retain decision-making rights about this; not retaining this function would create a double delegation issue)
- Matters reserved by member practices in the CCGs constitution that cannot be part of joint or lead arrangements

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

This amendment should address the "double delegation" issue, allowing CCGs to make collaborative arrangements for services delegated to them by NHSE – this would enable combinations of CCGs and local authorities to work together to commission care across a wider range of services. Under these arrangements NHSE would continue to be accountable for its functions but when NHSE delegates services, CCGs would be responsible for them.

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

Here, CCGs could come together to make decisions for their combined areas about delegated services, with NHSE also able to make joint decisions about its functions with a group of CCGs across their combined areas. At present, NHSE is only able to delegate functions to individual CCGs, limiting the scope to commission services across a wider geographical footprint where this makes sense for patients and local communities.

Specific proposals to delegate or jointly commission, such as armed forces healthcare or health and justice services, would need to demonstrate that they have a clear supporting rationale, as there are benefits in having a single national model to deal with these specific groups of patients. NHSE/I also plans to introduce specific safeguards in legislation (primary or secondary).

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

These changes allow for a single set of arrangements between NHSE and a number of CCGs. Without these changes, CCGs and NHSE would not be able to make decisions about specialised services in joint committee arrangements. NHSE would remain accountable for commissioning specialised services, which would continue to be supported by national standards of care, service specifications and clinical policies

determined by NHSE. The changes would also ensure that CCGs have a genuine stake in specialised services decision-making and spending of pooled resources, enabling integration of these services into wider care pathways within the terms of the joint arrangements.

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

The proposed changes would allow:

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

These changes would enable arrangements for section 7A services to be on the same footing as that of other NHSE functions, that is, to have the ability to jointly commission with, or delegate to, one or more CCGs so that local areas are able to make joined-up decisions about services for their populations. NHSE/I state that delegation and joint commissioning of section 7A services with one or more CCGs would enable local input into public health commissioning, whilst still retaining a consistent national approach where this works best.

I) Joined up National Leadership

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

NHSE/I argue that closer working is the agreed direction of travel and the responses confirmed that a single organisation should be created through legislation. This is also the clear stated public preference of the Boards of both NHSE and NHSI.

NHSE/I state that the legislative mechanism to achieve this should be to merge the functions of Monitor and TDA into the NHS Commissioning Board (NHS England) with appropriate modifications to those functions and some potential new functions. The "new" organisation would therefore be an existing statutory body, with the functions and staff of the other two national organisations transferred to it, with limited further change (other than the changes to functions proposed elsewhere in our proposals). This proposal would establish a single legal entity answerable to the Secretary of State for Health and Social Care and Parliament responsible for all aspects of NHS performance, finance and care transformation.

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

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

While some respondents were concerned about the loss of the benefits of separate a national representatives for commissioners and providers, NHSE/I argue that, rather than advocating for providers in isolation or commissioners in isolation, the NHS Long Term Plan demands that a 'one NHS' approach is needed.

Other recommendations

NHSE/I originally also proposed to provide the Secretary of State the power to transfer, or require delegation of, arm's-length body (ALB) functions to other ALBs, and create new functions of ALBs, with appropriate safeguards. However, NHSE/I did not find a consensus amongst respondents to this proposal, and also notes that the Health and Social Care Select Committee felt unable to support the proposition without greater clarity. NHSE/I concluded that there is no consensus which enables it to recommend the original proposal be progressed.

NHSE/I also note a question raised, in particular by the Royal College of Nursing, during the engagement exercise about the respective responsibilities of national organisations in relation to workforce functions. In response, it now also recommends that the Government should revisit with partners whether national responsibilities and duties in relation to workforce functions are sufficiently clear.

Next steps

NHSE/I have recommended to the Secretary of State that these proposals are included as an 'NHS integrated care bill' within the next Queen's Speech.

Progression of the bill faces several hurdles: in particular, whether the vote on the Queen's Speech passes (it is a confidence vote in the government, which has no majority) and in turn, whether an alternative government is formed or a general election is called. The Labour party has also publicly said it will oppose the bill.

It had originally been planned that, should the proposals be taken forward, a draft bill would be developed, followed by pre-legislative scrutiny and then re-drafting. This would take around ten months. Parliamentary time would then need to be found for the bill. However, it may now be that a bill is developed, rather than a draft bill, meaning that it would go straight to Parliament for consideration and enactment.

Were there to be a general election, we would expect an NHS bill to be included in party manifestos, and for any proposals for legislative change to be re-developed, potentially substantially depending on the make up and majority of the government, as well as the degree to which the government supports NHSE/I taking a lead (as opposed to the Department of Health and Social Care).