

Meeting in Common of the Boards of NHS England and NHS Improvement

Meeting Date: Thursday 28 February 2019

Agenda item: 02

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Report on: Building the case for primary legislative change

Introduction

1. The Health and Social Care Select Committee concluded in May 2018 that there are strong arguments for changing primary legislation, where it is a problem at a local level and acts as a barrier to integration in the best interest of patients. A month later, the Prime Minister invited the NHS to come forward with proposals for legislative change.
2. The engagement process preceding publication of the NHS Long Term Plan generated helpful suggestions for legislative change. Those set out in the Long Term Plan satisfied three tests. First, they must help solve specific practical problems that the NHS faces in being able to implement the Long Term Plan and improve health and care. Second, they should command broad NHS and public support. Third, they must avoid creating operational distraction triggered by a further top-down reorganisation.

Current position

3. It is possible to implement the *NHS Long Term Plan* without primary legislation. But legislative change could make implementation easier and faster. Consistent feedback throughout our engagement on the Long Term Plan was that the current legislative framework that governs the NHS gives considerable weight to individual institutions working autonomously, when the success of our plan depends partly on shared endeavour. Our experience of the rules for procurement, pricing and mergers is that they can stand in the way of collaboration and integration of care. To support this, we also want to enable greater join-up in the way national bodies work together and speak with one voice.

4. As requested by both the cross-party House of Commons Health and Social Care Committee and the Prime Minister, we have drawn up carefully targeted legislative changes which NHS leaders and clinicians judge would help NHS organisations to work collectively, as the public expects, in the interests of patients.

Core proposals

5. The primary focus of our proposals is to make it much easier to integrate services.
6. The Health and Social Care Act 2012 gave a significant emphasis to the role of competition in the NHS by formalising the role of the Competition and Markets Authority (CMA) in reviewing NHS transactions and assigning new responsibilities to Monitor as a competition authority. Whilst competition can in some circumstances help provide benefits to patients, we are concerned that the comparative weight that current legislation gives to competition will act as a drag on efforts to improve collaboration between NHS bodies and provide integrated care.
7. We are therefore proposing **a number of changes to both the CMA's and NHS Improvement's (Monitor) roles in respect of competition**. Specifically, we propose removing the CMA's function to review mergers involving NHS foundation trusts, removing NHS Improvement's competition requirements and removing the need for NHS Improvement to refer contested licence conditions or National Tariff provisions to the CMA.
8. We consider that it should be possible for NHS commissioners to arrange for NHS trusts and NHS foundation trusts to provide services without necessarily having to advertise these services and seek expressions of interest from the wider market. We propose **that the regulations made under section 75 of the Health and Social Care Act 2012 should be revoked and the powers in primary legislation under which they are made should be repealed**. The Long Term Plan makes specific proposals to strengthen patient choice and control, including the roll out of personal health budgets. Requirements in relation to patient choice would, therefore, continue under the separate regulations which currently impose requirements ('standing rules') on commissioners, as well as licence conditions for providers.
9. Alongside this we also propose that **arrangements between NHS commissioners and NHS providers are removed from the scope of the Public Contracts Regulations** and that NHS commissioners are instead subject to a new 'best value' test, supported by statutory guidance, when making such arrangements.
10. The National Tariff already offers significant flexibility to support new ways of delivering care. We are proposing **legislative changes that could nonetheless help provide more flexibility in developing new payment models**. Our

proposals would allow national prices to be set as a formula rather than a fixed value, so that the price payable can reflect local factors. They also would provide a power for national prices to be applied only in specified circumstances, for example allowing national payment prices for acute care to cover 'out of area' treatments but enabling local commissioners and providers to agree appropriate payment arrangements for services that patients receive from their main local hospital. We would also allow adjustments to the tariff to be made within a tariff period, for example to reflect a new treatment, rather than have to consult on a new tariff in its entirety for even a minor proposed change. We also propose, once integrated care systems (ICSs) are fully developed, **removing the current ability for providers to seek NHS Improvement's agreement for unilateral local modifications to national tariff prices**, so that the onus is on providers and commissioners to agree any local variations to national prices.

11. Through the development of ICSs, commissioners and providers are increasingly coming together to plan services in a much more collaborative way. Some local health systems have expressed interest in going further and bringing some services together under the responsibility of a single provider organisation, supported by a single contract and a combined budget.
12. Where it is difficult for commissioners to identify an existing organisation that could take on responsibility for an integrated care provider contract, we propose the Secretary of State should be given clear **powers to establish new NHS trusts for the purposes of providing integrated care**. Taken together with the procurement changes we propose, this would support the expectation in the NHS Long Term Plan, and the Health and Social Care Select Committee's recommendation, that the Integrated Care Provider (ICP) contract should be held by public statutory providers.
13. We are suggesting new powers to ensure the NHS is able to manage resources better. There has been an increasing trend in recent years to trusts (particularly hospital trusts) joining forces through mergers or acquisitions so that the unified trust can better manage resources across multiple local sites, with strong potential benefits for standardisation of clinical, workforce and operational processes. Whilst we would generally hope and expect changes of this kind to come about through consensus, there may be occasions where an individual trust is reluctant to consider changes that could serve the wider interests of the NHS and the patients it serves. We therefore propose **that NHS Improvement should have targeted powers to direct mergers or acquisitions involving NHS foundation trusts, in specific circumstances only, where clear patient benefits have been shown**.
14. We are also proposing that NHS Improvement should have **powers to agree annual capital spending for NHS foundation trusts**, in the same way that it can currently do for NHS trusts. This would help remove the current risk that high-priority capital expenditure in non-foundation trusts is unfairly constrained; help NHS Improvement work more effectively with local health systems to

improve decisions on the scheduling of large capital spending for the benefit of patients; and help ensure that the Government and NHS collectively does not exceed the overall capital spending limits prescribed by Parliament.

15. The responsibility for planning and funding the provision of health services is split across different organisations. We frequently hear this acts as a hindrance to integrating care for patients and making best use of public resources. Public health services (to help prevent ill-health), primary care, hospital care and specialist mental and physical healthcare are organised by different bodies. We want to join up the commissioning of these services but without creating the distraction of major organisational re-structuring.
16. We are therefore suggesting proposals to promote collaboration by **removing the legal barriers that limit the ability of CCGs, local authorities and NHS England to work together and take decisions jointly**. We want to enable CCGs to carry out delegated functions, as if they were their own, and enable groups of CCGs in joint and lead commissioner arrangements to make decisions and pool funds across their functions.
17. We want NHS organisations, primary care networks, local government and other community partners to work together as integrated care systems (ICSs) to jointly plan and improve the way care is delivered. Although CCGs and NHS providers can work together informally, the current law prevents them from setting up joint committees to take joint decisions in the interests of their local population.
18. We believe that there should be express **powers for organisations to create joint committees and for CCGs and NHS providers to be able to make joint appointments**. This would enable joint decisions for the common good, agreeing priorities for improving quality of care, planning how they will achieve their shared aims and making the best use of the collective resources available to them. With local government, we would want to look at how existing provisions for joint working between local government and the NHS might be improved in the light of these proposed changes. Alongside this we would also like to **allow CCGs to appoint to their governing bodies a designated nurse and secondary care doctor from local providers**.
19. NHS bodies are legally bound – and should continue to be bound – by strong duties to provide or arrange high quality care and exercise financial stewardship as individual organisations. But, although there are general duties on NHS bodies to cooperate, current legislation does not give them explicit responsibility for collaborating with each other and with neighbouring health systems to improve population health and the use of NHS resources. We therefore propose introducing **a new shared duty for CCGs and NHS providers (NHS trusts and foundation trusts) to promote and contribute to a ‘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.

20. Finally, in the spirit of the **closer working relationship between NHS England and NHS Improvement** we make proposals to bring our organisations closer together, beyond the current limits of legislation. We seek views on how far this closer working should extend, ranging from fully merging our organisations to providing more flexibility in our working arrangements.

Approach to engagement

21. Reaction to the legislative proposals set out in the NHS Long Term Plan was positive with broad welcome for their rationale and aims.
22. As we set out more detail on our proposals today, we want to start a broad process of engagement with the NHS, its partner organisations and those with an interest in how our health service operates.
23. The aim of this process will be to ensure our proposals are sufficiently focused to help deliver our ambition to improve NHS services for everyone working in them and using them. We would hope Parliament can take these proposals forward with the broad support of the NHS.
24. Our engagement period starts today and will run until 25 April 2019. During this time, we will actively reach out to interested organisations through our ongoing discussions on implementing the Long Term Plan, at targeted stakeholder events and via a questionnaire that is open to everyone and can be found online via the Long Term Plan webpage. Once responses have been received and considered, we will publish a report which sets out the views received and makes firm recommendations for the Secretary of State.
25. We expect the Health and Social Care Select Committee to continue their work and scrutiny in this area. We hope to work with them in explaining and developing our proposals and sharing the feedback and support for them as part of that process.

Recommendation

26. The Boards are invited to agree the launch of our engagement on proposed primary legislative change.