

## Response from NHS Clinical Commissioners to NHS England and NHS Improvement's proposals for possible changes to legislation

April 2019

### Executive summary

- We welcome NHS England (NHSE) and NHS Improvement's (NHSI) proposals to change legislation, as many of their proposals reflect the issues our members have raised as barriers to collaborative working.
- Generally we have heard that clinical commissioning groups (CCGs) are in favour of tackling these issues, but want to ensure the solutions proposed by legislative change are well-thought through and will have minimal unintended consequences.
- CCGs are already taking steps to work more collaboratively and whilst considering these proposals, it must be recognised that resorting to legislative change will be a convoluted and time-consuming process. CCGs and others in the NHS should not be waiting for legislative change to alter their approaches – and NHSE and NHSI must continue to smooth the path to integration as these proposals are developed and discussed.
- With regards to specific proposals, CCGs welcome several principles that sit behind them – to share responsibility for health, to ensure there is aligned regulation and assurance, to clarify and simplify governance for joint commissioning, to enable joint committees, to reduce the burden of procurement and to reform payment systems.
- However whilst supporting the emphasis on collaborative working, it is imperative that the unique and critical role of CCGs is not diluted or lost – so they are able to maintain their role as the 'purchaser' of healthcare for their populations and make best use of the NHS pound.

### 1. NHS Clinical Commissioners

- 1.1. NHS Clinical Commissioners (NHSCC) is the membership body of Clinical Commissioning Groups (CCGs). Established in 2012, we have around 90% of CCGs in membership. We offer a strong national voice for our members on specific policy issues and support them to be the best they can to commission services effectively for their local populations.
- 1.2. We welcome NHSE/I's proposals for possible changes to legislation. Our members will be directly affected by the proposals and have previously flagged that there could be some changes in the law that would enable a smooth and faster path to collaborative working.

### 2. Overarching intention and response to these proposals

- 2.1. CCGs were established by the 2012 Health and Social Care Act, and therefore their statutory duties and governance are intimately tied to the legislative framework that currently underpins the NHS.
- 2.2. As noted in the NHSE/I legislative proposals, the Long Term Plan (LTP) aims to improve services. One way of achieving this is through collaborative, place-based and person-centred working. Increased integration of commissioning and delivery of health services has been pursued for some



time. CCGs are in favour of taking a more integrated approach and have already started on the path to collaborative working. Many are making more strategic commissioning decisions on a larger scale<sup>i</sup>, with arrangements that bring together several CCGs or even through formal mergers<sup>ii</sup>. There are many examples of joint working with local authorities<sup>iii</sup>. They are also working with providers in a different way – in some cases, sharing responsibility for service redesign with provider colleagues in the wider system<sup>iv</sup>.

2.3. In response to the HSC Committee's inquiry into integration in 2018, and to the prime minister's invitation<sup>v</sup> to flag any areas where legislation could be changed, NHSCC asked members whether there were areas which pose barriers to success when trying to work more collaboratively.

2.4. Our members highlighted several issues:

- Sharing responsibility – so that other bodies within a system would also be responsible for improving health outcomes
- Ensuring assurance and regulation was aligned
- Clarifying governance arrangements – e.g. allowing the formation of joint committees, or to avoid 'double delegation'
- Reduce the burden of procurement
- Payment reform so that payment would not always default to paying on an activity basis

2.5. CCGs also recognised that many of these issues were already being tackled through existing efforts. Since top-line legislative proposals were published in the LTP, CCGs have flagged that there are examples where collaborative working is happening successfully, and therefore legislative change may not be needed.

2.6. In discussing this with NHSE/I colleagues, we recognise that these proposals are intended to smooth and accelerate progress that has already been made, and potentially simplify or solidify approaches that have been used already rather than radically transform the NHS legislative framework.

2.7. As there are CCGs and systems making progress already, it is also important that these changes provide tools for them to use if and when they choose to, rather than introducing constraining requirements – providing enabling tools rather than a prescriptive requirement.

2.8. In addition, as the process to develop, change and implement revised legislation will take time, it is important that efforts continue within the current legislative framework to enable more collaborative working. This includes individual organisations changing their approach, but also through the work of national bodies such as NHSE/I. This could involve sharing documents such as Mechanisms for Collaboration<sup>vi</sup>, reinforcing guidance on procurement flexibility<sup>vii</sup>, changing payment processes as outlined in the most recent planning guidance<sup>viii</sup>, or NHSE/I (and others, such as the CQC) taking a new approach to regulation.

### 3. Specific proposals

The NHSE/I proposals were divided into 9 areas. However, many of them are interlinked. The importance of these proposals to CCGs also varies – some are going to directly impact them whereas others will be more indirect. Therefore our response prioritises the proposals which are especially pertinent to CCGs.

#### 4. **Every part of the NHS working together: Joint Committees of CCGs and NHS providers**

CCGs and providers have been coming together and using forums or alliance agreements – as detailed in *Mechanisms for Collaboration*. We recognise that, although helpful, this has the potential to lead to confusion over accountability and the need to take decisions made in these partnership settings back into formal governance arrangements for ratification.

4.1. Therefore, the ability to form a new committee between commissioners and providers does provide the scope to cement and streamline existing relationships – and could essentially give Integrated Care System partnership boards a statutory footing.

4.2. However, when considering this in practice, it is important to consider:

- Does this allow for joint working between *all* parties in a health and social care system? As noted, there are existing ways to form section 75 partnership arrangements with local authorities. It is vitally important that this new arrangement can include local authorities so their involvement is secured. It is also important that specialised commissioning representatives are involved.
- There are also complexities relating to scale and geography. Some providers may be required to be involved in several systems due to the breadth of communities they serve.
- Similarly, if these arrangements focus on a ‘system’ (ICS) level, we do not want to lose joint working at a more local ‘place’ level: establishing joint committees could extend to place level too. The role of Health and Wellbeing Boards and their role should be considered.

4.3. Governance arrangements for these joint committees also need to be clarified. We understand that accountability ultimately is not changing, but recognise that transparency of decisions made by new joint committees will be essential.

4.4. It is welcome that the ‘new joint commissioner/provider committees would not do away with the existing responsibilities of CCGs and NHS providers’ as it is essential to maintain the key role of CCGs – to make unconflicted decisions to improve the health of their local population, and ensure that their local budget is being used as effectively as possible.

4.5. Forming these new committees should not undermine the role of commissioners in conducting their functions of prioritisation, purchasing services and holding providers to account.

4.6. Underpinning these new arrangements would require removing individual organisation control totals, and ensuring there is aligned, system-wide assurance. The shared responsibilities also proposed would equally add to the success of these joint committees.

4.7. It was also felt that collaborative working between commissioners and providers was still dependent on trust and strong relationships. It was felt unlikely that statutory changes would lead to drastically different relationships or behaviour – so there would still need to be other, cultural efforts to achieve successful joint committees.

4.8. **Every part of the NHS working together: CCG Governing Bodies**

Changing restrictions on governing body membership was seen to be a helpful proposal, as some CCGs have struggled to appoint to vacancies. More flexibility around appointments is welcome, although there will need to be guidance about avoiding conflicts of interest and ensuring they will have sufficient capacity, depending on expectations about their roles on joint committees in addition to the CCG's governing body.

Another issue raised about governance was the tension felt when decision making on issues that may have different views amongst member practices compared to the governing body. However, it's not clear that there are legislative solutions to this but it could be considered when reviewing governing body composition and role.

#### **4.9. Every part of the NHS working together: Joint Appointments**

There are some existing examples where appointments are being made between commissioners and providers. This can be beneficial in certain circumstances, however, it was felt very important that restrictions were placed on the types of functions that could be delivered by someone with a jointly appointed role.

A joint appointment could not be of an accountable officer, or someone who was responsible for 'commissioner only' activities, such as contracting, procurement and resource allocation. However, a 'director of transformation' role could perceivably be a shared role. Rather than being prescriptive about what job titles could not be jointly appointed, we suggest that there are stringent criteria that ensure the joint appointment does not lead to insurmountable conflicts of interest.

There are also examples of successful joint appointments between local government and CCGs. We would like to ensure this proposal could allow for a 'tripartite' (or potentially multi-party) joint appointment to be truly representative of a system-wide, collaborative role.

### **5. Getting better value for the NHS**

Requirements to procure services by CCGs have been regarded as a barrier to successful collaborative working. CCGs have said that where a provider is performing effectively, they feel there might be negligible benefit in undertaking a time-consuming and costly procurement exercise. However, there was also recognition that procurement was a useful option to use as this could encourage innovative approaches and quality improvement from providers.

5.1. It was also noted that there is existing flexibility within the act and CCGs can adopt different approaches to procurement, but this is often based on their appetite for risk. Currently CCGs may receive conflicting legal advice about whether or not they are required to undertake procurement.

5.2. Ultimately, the ability to have more reassurance when deciding not to procure is welcome. More detail is needed on what a 'best value' test would involve, and we look forward to further discussions about this. Members did say that this test should assess how 'reasonable' it would be to procure and what benefits it would bring.

5.3. Introducing an alternative to procurement - such as a best value test - would need to be less onerous for commissioners to use, and would also need to provide a mechanism for conflict resolution.

5.4. It was also recognised that removing CCGs and NHS bodies from these procurement regimes may then lead to problems with joint commissioning arrangements with local authorities. Therefore consideration would need to be made when changing legislation to ensure that there wouldn't be two different regimes for procurement regulation that apply to local authorities and CCGs separately.

6. **Patient choice** – we appreciate that the proposals are trying to maintain the primacy of patient choice in the NHS. In our view, maintaining patient choice may be more about personalised medicine in future, so that people can make shared decisions about their care. This may mean the continuation of choosing where or who would provide an elective procedure by any qualified provider (including independent sector providers) – if they are delivering a high quality service, but 'choice' can be explored in different ways.

#### 7. **Increasing the flexibility of national NHS payment systems**

CCGs have flagged that using the 'payment by results' (PBR) tariff as the default payment mechanism may stymie collaborative working. This default may mean that systems do not negotiate a better arrangement that takes into account paying per activity may not lead to the best outcomes, and there could be other mechanisms adopted. For example, providers may not have as much incentive to reduce unwarranted activity or demand if they are paid per episode.

7.1. Our members have already been pursuing alternative ways to pay for services, and we have also seen national introduction of different options, such as the blended payment scheme for emergency care that was introduced as the default in the 2019/20 operational planning guidance.

7.2. The proposals to allow for more flexibility within payment systems is therefore welcomed, although we do seek clarity over:

- Where it proposes that the prices can be set as a formula rather than a fixed value, so that the price payable can reflect local factors – what sort of local factors are going to be considered?
- Would this be the case for all services?

7.3. It was noted that retaining national prices is a useful benchmark even if local changes are made, and that PBR provides helpful data. It was also recognised that the tariff has introduced some simplicity so that every activity does not need to be subject to protracted discussions. It was therefore felt that – like with other proposals – legislative change should maintain using the tariff as an option.

#### 8. **Planning our services together**

Simplifying arrangements so that CCGs can jointly commission primary care without the barrier of 'double delegation' was felt to be helpful. Giving flexibility with regards to commissioning some functions (i.e. those covered by section 7a) was felt to be important and welcome. These changes have the potential to reduce fragmentation and join up care for patients.

The inclusion of specialised commissioning – and the recognition that it would need careful consideration of the relevant population size – is also welcome. However, it is important to understand that this is not changing the list of services (re-designating) that are on prescribed specialised services list. There would need to be understanding of the most appropriate levels of commissioning for specialised services.

There are also some services which are currently excluded from section 75 arrangements between local authorities and CCGs (e.g. surgery, radiotherapy, termination of pregnancies, endoscopy, the use of class 4 laser treatment and other invasive surgery; and emergency ambulance services) – it was felt whilst considering more flexibility for joint commissioning, these exclusions could be reviewed.

#### **9. Shared responsibility for the NHS**

This proposal was welcome as it was felt it would encourage collaborative working, and giving wider responsibilities was initially raised by CCGs as one way to facilitate integration. It would need to be underpinned by an aligned approach to regulation, and is also potentially needs clarification about how to define ‘the local population’ that a provider would have a duty towards.

The proposals explicitly place this new shared duty on ‘NHS providers of care’ – and it would be useful to clarify how, if at all, this would impact on independent sector providers, primary care networks and local authorities.

There is also the possibility that these shared duties could be extended further, to explicitly mention tackling wider determinants of health and reducing health inequalities.

#### **10. Promoting collaboration**

Several CCGs have merged – their mergers are not subject to the Competition and Markets Authority (CMA) or Monitor’s role in adjudicating these. Similarly, the role of the CMA in contested licence conditions or changes to tariff are of less relevance to CCGs.

However, CCGs do take an interest in the service configuration of the providers in their local system. They have experienced where a potential provider merger has been referred for CMA investigation. It was felt that CMA involvement was unnecessary and this may not take into account wider views on the benefits of the merger. Our members are therefore supportive of removing the CMA’s powers to review mergers involving NHS foundation trusts. It makes sense for NHS Improvement having a continuing role reviewing proposals, and should take into account commissioner views because of CCGs’ legitimate interest and expert views about provider configuration.

#### **11. Integrating care provision**

CCGs perceive the ability to form new NHS trusts would be beneficial. However they have questioned whether it’s likely it will be widely used if it requires the consent of providers. Although alternatives do exist – such as alliances, or the integrated care provider contract – they can be difficult to establish and therefore this may be adopted by some. We could see that an ICT may be able to join up care between different types of providers and therefore provide a service for patients that improves experience.

#### **12. Joined-up national leadership**

Combining some functions held by NHS England and NHS Improvement are welcome, as CCGs working in their local systems have experienced duplicative and at times conflicting information and regulation.

Their joined-up leadership should hopefully lead to aligned assessment frameworks, with what is measured and assessed made clear from the joined up NHSE/I. It would be helpful to have single set of reporting on services. This should also

### 13. **Managing the NHS's resources better**

Our members have not explicitly shared their views on these proposals.

### 14. **Additional areas of potential legislative change**

Our members have flagged that VAT exemptions for NHS bodies is not sufficiently extensive and this therefore imposes a 20% additional cost on many transactions which CCG are commissioning.

Legislative changes could therefore consider extending VAT exemptions beyond their current scope.

### **For more information**

If you would like any further detail on our response please do not hesitate to contact our Head of Policy and Delivery, Sara Bainbridge at [s.bainbridge@nhsc.org](mailto:s.bainbridge@nhsc.org)

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<sup>i</sup> <https://www.nhsc.org/policy-briefing/6323/>

<sup>ii</sup> <https://www.nao.org.uk/report/a-review-of-the-role-and-costs-of-clinical-commissioning-groups/>

<sup>iii</sup> <https://www.nhsc.org/latest-news/shifting-centre-gravity/>

<sup>iv</sup> <https://www.nhsc.org/policy-briefing/driving-forward-system-working-a-snapshot-of-early-progress-in-collaborative-commissioning/>

<sup>v</sup> <https://www.gov.uk/government/news/prime-minister-sets-out-5-year-nhs-funding-plan>

<sup>vi</sup> [https://www.nhsc.org/wp-content/uploads/2019/01/181119\\_Mechanisms\\_for\\_collaboration.pdf](https://www.nhsc.org/wp-content/uploads/2019/01/181119_Mechanisms_for_collaboration.pdf)

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[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/283505/SubstantiveGuidanceDec2013\\_0.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/283505/SubstantiveGuidanceDec2013_0.pdf)

<sup>viii</sup> <https://www.england.nhs.uk/wp-content/uploads/2018/12/nhs-operational-planning-and-contracting-guidance.pdf>