**Summary: Intervention and Options**

What are the policy objectives of the action or intervention and the intended effects?

This Impact Assessment (IA) mainly covers the subset of legislative changes in the Health and Care Bill that have the unified aim of supporting the effective delivery of the NHS Long Term Plan whilst strengthening democratic accountability. Within this, the individual measures are broadly aimed at: one, enabling closer working between different parts of the health and care systems, such as through joint commissioning or the establishment of Integrated Care Systems; two, reducing bureaucracy to enable services to be arranged to better meet the needs of local populations, lessening the administration associated with procurement; three, strengthening accountability for decision-making whilst improving public confidence. This IA also covers some provisions which are not in the NHS Long Term Plan but are closely linked to the three themes of the Bill, such as data sharing. The Bill also makes some wider legislative changes to tackle known issues with the existing framework; these measures are not covered in this IA.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

This IA covers legislative changes developed by the Department of Health and Social Care, working with a breadth of stakeholders including NHS England and NHS Improvement, and the Ministry for Housing, Communities and Local Government. These have been developed from horizon scanning of future roadblocks for the health and care system, and build on some of the legislative changes which NHS England and NHS Improvement previously recommended to the Government in autumn 2019; the latter have been developed after extensive public engagement. The new measures also build on learning from ways of working implemented during the Covid-19 response. Given the breadth of the package of measures this IA is focussed primarily on the leading options for each of the proposals and specific legislative changes. Impacts are by default compared against a ‘do-nothing’ option.

Will the policy be reviewed? It will be reviewed. If applicable, set review date: Not applicable

<table>
<thead>
<tr>
<th>Cost of Preferred (or more likely) Option (in 2019 prices)</th>
<th>Business Impact Target Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Net Present Social Value</td>
<td>Business Net Present Value</td>
</tr>
<tr>
<td>Unquantified</td>
<td>Unquantified</td>
</tr>
</tbody>
</table>

What is the problem under consideration? Why is government action or intervention necessary?

There is stakeholder consensus that greater collaboration within the English health and care system will enable the NHS to deliver effective, timely and continuous care to patients. The need for this is compounded by both the increasing complexity of health care needs of patients and rising demand from an aging population, as well as the challenges of responding, and learning from responses, to health emergencies such as the Covid-19 pandemic. Legislative change alone cannot deliver reform, but it can support new ways of working and remove specific barriers created by existing primary legislation. Removing these barriers will be vital to support the NHS and wider health and care system as it recovers from Covid-19 impacts.

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible Minister: ________________________ Date: 10/01/2022
**Summary: Analysis & Evidence**

**Policy Option 1**

**Description:**

**FULL ECONOMIC ASSESSMENT**

<table>
<thead>
<tr>
<th>Price Base Year</th>
<th>PV Base Year</th>
<th>Time Period Years</th>
<th>Net Benefit (Present Value (PV)) (£m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Low: N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>High: N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Best Estimate: N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COSTS (£m)</th>
<th>Total Transition (Constant Price)</th>
<th>Average Annual (excl. Transition) (Constant Price)</th>
<th>Total Cost (Present Value)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>High</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Best Estimate</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Description and scale of key monetised costs by ‘main affected groups’**

The proposals set out in this IA are complex and mainly entail enabling powers which either lead to practical but limited changes; require secondary legislation or consultation before practical changes can occur; and/or, require system behavioural change before practical changes come into force. It is not possible to robustly estimate an overall cost impact by affected group. An assessment of impacts on businesses, including small or micro businesses, and wider impacts such as those on the environment, trade and competition, will be completed where appropriate alongside secondary legislation.

**Other key non-monetised costs by ‘main affected groups’**

There may be opportunity costs of the proposals which cannot be quantified. For example, if the Secretary of State chooses to exercise new powers of direction over NHS England, any benefits of greater autonomy may be forgone. Other non-monetised costs may include business disruption, such as organisational costs in adapting to new regulations. These are typically sunk costs and are already part of the counterfactual.

**BENEFITS (£m)**

<table>
<thead>
<tr>
<th>Total Transition (Constant Price)</th>
<th>Average Annual (excl. Transition) (Constant Price)</th>
<th>Total Benefit (Present Value)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>High</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Best Estimate</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Description and scale of key monetised benefits by ‘main affected groups’**

Benefits relating to empowering organisations, reducing bureaucracy and clarifying accountability have not been monetised in this IA as a robust estimation of likely effects is not possible. Where specific proposals could have their monetised benefits defined these are noted in the relevant sections.

**Other key non-monetised benefits by ‘main affected groups’**

The package of measures clarifies the law and better enables providers, commissioners and local authorities to collaborate and integrate at scale. A move towards greater collaboration in the English health system is widely seen as central to meeting the challenges of rising demand and complex needs, and this is no less important during the Covid-19 response and recovery period. A cost of some specific proposals, if these powers are exercised by the Secretary of State is a potential loss of autonomy for individual organisations on specific decisions. However, this is balanced by increased power over other types of decisions. The proposals recognise that responsibility and accountability are pooled across the system, and ensuring strong collaboration between organisations will strengthen the ability of organisations to respond adequately to the challenges facing them.

**Key assumptions/sensitivities/risks**

Discount rate (%): N/A

The implementation of the proposals will be affected by the ongoing response to Covid-19, and how the system works to recover from this period. There is also a risk – associated with any change programme, even if intended to be limited – that resources are spent on implementing a new system to the detriment of output. However, these risk are expected to be mitigated by the fact that these legislative proposals support the existing changes the NHS has already been pursuing. Some proposals have aims of amending specific pieces of legislation that are not thought to be working well, e.g. proposals on the national tariff to allow for flexibility for local pricing; while others – such as the proposals on competition, procurement processes and joint committees – will reduce bureaucracy for health systems.

**BUSINESS ASSESSMENT (Option 1)**

<table>
<thead>
<tr>
<th>Direct impact on business (Equivalent Annual) £m:</th>
<th>Score for Business Impact Target (qualifying provisions only) £m:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Costs: N/A</td>
<td>Net: N/A</td>
</tr>
<tr>
<td>Benefits: N/A</td>
<td>Not a qualifying provision</td>
</tr>
</tbody>
</table>
Health and Care Bill: Evidence base for Impact Assessment

Background and Overview

The response to Covid-19 in England has seen the enactment of provisions in the Coronavirus Act 2020, giving emergency powers to the Government to respond to the immediate pressures of the pandemic flexibly and with parliamentary consent. The implementation of this legislation will continue to be reviewed within its own context, and this Bill should be viewed separately to the Coronavirus Act in its intent and design. The Coronavirus Act 2020 contains sunset clauses, meaning it will expire two years after passage. The provisions contained in the Health and Care Bill will set the strategic direction of the health service over the longer term, not just for the duration of the Covid-19 pandemic.

Over the past few years, the health and care system in England has undergone a process of substantial operational change. This evolution, which has been led by the NHS, has occurred within the existing legislative framework but has often required health and care bodies to find complex workarounds. The stage has now been reached where existing legislation (which, for example, sets out in great detail the distinct roles and responsibilities for individual organisations in the system) requires updating to better support the needs of the health and care system to continue to evolve to meet the changing needs of our population.

Many NHS commissioners and providers, along with local authorities and voluntary sector partners, have started to implement collaborative working mechanisms. This has happened through the creation of new types of integrated provider model, as set out in the Five Year Forward View, and latterly through Sustainability and Transformation Partnerships (STPs) and their evolution into Integrated Care Systems (ICSs). As of April 2021, all areas of England are covered by an ICS.

The development of these collaborative mechanisms has been progressing in recent years: all STPs have now become ICSs. NHS England and NHS Improvement set out on their latest Integrating Care paper: “The response of the NHS and its partners to Covid-19 and a further year of ICS development has increased the appetite for statutory “clarity” for ICSs and the organisations within them. With an NHS Bill included in the last Queen’s Speech, we believe the opportunity is now to achieve clarity and establish a “future-proofed” legislative basis for ICSs that accelerates their ability to deliver our vision for integrated care”.

The current system has complex accountability mechanisms at local and national level. These were largely created by the Health and Social Care Act 2012, which centred on the principles that the NHS should be able to operate through a quasi-market approach, meaning that NHS organisations would be sustained by competition which would be the main driver behind improvements to quality and efficiency. In many ways, the system has not operated as the original policy envisaged, and lack of system alignment is one of the areas highlighted by the service and independent DHSC-funded research as requiring improvement, especially as the demographic changes that require a stronger emphasis on joined-up care continue. The Bill will create a more nuanced approach to the competition regime, that gives due weight to collaboration, rather than competition alone. Competition

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2 In 2014 the NIHR DHSC Policy Research Programme funded four projects under the Health Reform Evaluation Programme exploring different aspects of the new health and social care system following the Health and Social Care Act 2012. The four projects explored: the new NHS commissioning system, diversity of healthcare provision, the establishment and operation of Health and Wellbeing Boards, commissioning public health services. A full list of references for this programme of work is provided at Annex A.
will still play an important role in improving services delivered to NHS patients, for example, through the provider selection regime, strengthened patient choice rights and the Competition and Markets Authorities continued oversight of the private healthcare market.

The Health and Care Bill proposals therefore learn from the lessons of the evolution of the NHS since 2014, and the publication of the Five Year Forward View\(^3\), as well as the specific experience of the Covid-19 response, and are expected to enable the NHS to meet the challenges ahead by making permanent the principles of collaboration and agility of decision-making. Many measures covered in this Impact Assessment (IA) are enabling measures: they either require secondary legislation to come into force (e.g. powers of direction), or they remove some existing requirements without preventing their continued operation (e.g. provider selection).

**Scope of the Final Stage Impact Assessment**

In January 2019, through the publication of the Long Term Plan\(^4\), the NHS set out proposals for legislative change to support the NHS to do the right things more easily. Following this publication, the NHS engaged with the public, patients, NHS staff and a broad range of representatives from across the health and social care sectors on possible legislative changes. In September 2019, following extensive consultation, NHS England published their final recommendations\(^5\). These LTP proposals are the focus of this IA; some new measures, closely linked to this core focus, are also considered.

Nonetheless, Bill proposals go beyond this core focus and aim to introduce specific changes which will benefit patients and citizens in the years ahead — measures are wide-ranging, spanning areas from professional regulation to hospital food standards\(^6\). These additional, specific interventions are considered in either standalone IAs, or, the Additional Measures Impact Assessment. The Health and Care Bill Impact Assessment Summary Document sets out the IAs completed as part of the Bill and where to find them. In many cases, supporting evidence is already in the public domain or consultation processes are ongoing. A list of all measures considered in this IA is specified in Table 1 of the next section.

Unless otherwise stated, future references in this IA to proposals, or measures, refer only to those covered by this analysis, rather than all proposals in the Bill.

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6 All legislative proposals for a Health and Care Bill are detailed in the White paper, ‘Integration and Innovation: working together to improve health and social care for all’.
Principles underlying the Health and Care Bill

The measures in the Health and Care Bill which directly implement or build on NHS England’s original recommendations for legislative change to support implementation of its Long Term Plan (LTP) follow three themes, all of which are integral for helping the system to recover from the pandemic and transform patient care for decades to come. These three core themes are the focus of this Core IA and are detailed below.

Alongside these LTP measures, there are additional proposals to make targeted changes to allow the Government to support the social care system, improve quality and safety in the NHS, to grant the flexibility to take public health measures and to implement worldwide comprehensive reciprocal healthcare agreements. Many of these measures also support the core aims directly or indirectly. They reflect the evolution of the Health and Care System since the Health and Social Care Act 2012. They also encompass opportunities arising from external factors, such as increased legislative flexibility following our departure from the European Union, the changes in the way healthcare is delivered because of the coronavirus pandemic, and extraordinary advancements in technology and medicines. More details on the IAs associated to this theme can be found by referring to the Impact Assessment Summary Document.

I. Working together and supporting integration
These proposals intend to make it easier for NHS organisations and local authorities to work together to deliver their health and care functions, given the interdependent nature of these functions. This could be through producing a joint plan of the health and care needs of their local populations; or agreeing for an organisation’s functions to be exercised by another body.

II. Reducing bureaucracy
Proposals under this theme intend to remove unnecessary bureaucracy and speed up decision-making processes to enable swift actions. In line with NHS England’s recommendations, the aim is to strip out unhelpful rigidities in the legislation, where they fail to enhance accountability, or necessitate complex or bureaucratic workarounds and make it difficult for the system to integrate and adapt over time as needed.

III. Ensuring accountability and enhancing public confidence
While accountability can mean different things in different contexts, a definition offered by the King’s Fund in relation to accountability in the NHS illuminates what the proposals relating to accountability in this Bill are trying to achieve:

“Accountability typically refers to a relationship involving answerability, an obligation to report, to give an account of, actions and non-actions. This indicates that there is an assumed expectation of the need to report and explain, either in person or in writing.

Accountability implies that there may be consequences (or sanctions) if the ‘account-giver’ is not able to satisfy the ‘account-holder’ that he or she has fulfilled the objectives set or made effective use of the resources allocated. Klein and New (1998) distinguish between ‘strong’ accountability, where there are sanctions if performance or the account of conduct is unsatisfactory, and ‘soft’ accountability, where an actor is required to justify performance in public (or at least in a transparent process) but no direct sanctions may apply other than perhaps public shaming.”

In the context of this IA, accountability most frequently refers to arrangements for NHS England and NHS Improvement to report and explain their actions to the Secretary of State for Health and Social Care, and for the Secretary of State to respond in a range of ways if he is not satisfied with these explanations. The changes in this group also include measures where NHS England might be required to exercise any of the Secretary of State’s public health functions.

Many of the proposals will enable changes under more than one theme, as highlighted in Table 1. Shaded squares in Table 1 identify a proposal’s main theme as defined by the White Paper. There is one unique proposal – the power of direction over public health functions – which has been included in this IA even though it is primarily an additional proposal to support public health; this is due to the strong overlap this proposal also has with the third theme, on ensuring accountability and enhancing public confidence.

Table 1: Categorisation of Bill proposals considered in the IA by theme

<table>
<thead>
<tr>
<th>Proposal group</th>
<th>I. Working together and supporting integration</th>
<th>II. Reducing bureaucracy</th>
<th>III. Ensuring accountability and enhancing public confidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Merging NHS England and NHS Improvement</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>2. Establishing Integrated Care Systems in law</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>3. Enabling the establishment of Joint Committees (continued) Joint Appointments</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Collaborative commissioning</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>5. Triple Aim</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Duty to Collaborate</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Care Quality Commission reviews of Integrated Care Systems</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>8. Data sharing</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>9. Foundation Trusts capital spend limit</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>10. Competition</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Provider selection and Choice</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>12. National Tariff</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>13. New trusts</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>14. Special Health Authorities Time Limits</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>15. Arm’s-Length Bodies transfer of functions power</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>16. General power to direct NHS England</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>17a. The NHS Mandate (and Better Care Fund)</td>
<td></td>
<td></td>
<td>X</td>
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<tr>
<td>17b. Amendment on Cancer Outcomes in the NHS Mandate</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>18. Reconfiguration of services: intervention powers</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>19. Public Health power of direction</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>20. Abolishing Local Education Training Boards</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>21. Workforce accountability</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>22. Designating Integrated Care Boards as Operators of Essential Services under NIS Regulations</td>
<td>X</td>
<td></td>
<td>X</td>
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</tbody>
</table>
Costs and benefits

It is difficult to predict precisely the occasions when the enabling provisions in the Health and Care Bill will be used, as the changes will give health and care organisations greater freedom to collaborate and arrange services in the best interests of their population at a local level, with appropriate oversight. The impact of the three core themes will therefore vary substantially.

These variations could occur because of the individual organisations involved or the circumstances in which the provisions are being exercised. As a result, the costs and benefits of these proposals are not monetised in this IA. Many of the proposals will not place direct costs on health and care organisations purely by their enactment, with costs only being a possibility at a later stage depending on how organisations choose to deploy the provisions. Where some of the proposals trigger costs – such as with the creation of statutory ICBs, or mandatory data collection from social care providers – these are expected to be limited and with benefits to the organisation’s wider activities. The Impact Assessment Summary Document highlight where specific impact tests have been undertaken to examine wider impacts of several proposals in this impact assessment. Table 2 summarises whether different measures are expected to: lead to practical but limited changes flowing directly from primary legislation; require secondary legislation or consultation before practical changes occur; and/or, require system behavioural change before practical changes come into force. In the case of the new intervention powers the impact will only be felt directly when Secretary of State makes a direction and intervenes.

Table 2: Categorisation of proposals by principle, and measure impact

<table>
<thead>
<tr>
<th>Proposal group</th>
<th>Principle</th>
<th>Measure impact</th>
<th>Principle</th>
<th>Measure impact</th>
<th>Principle</th>
<th>Measure impact</th>
<th>Principle</th>
<th>Measure impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Merging NHS England and NHS Improvement</td>
<td>X X X X</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2. Establishing Integrated Care Systems in law</td>
<td>X X X X</td>
<td></td>
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<tr>
<td>3. Enabling the establishment of Joint Committees</td>
<td>X X</td>
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<td></td>
</tr>
<tr>
<td>3 (continued) Joint Appointments</td>
<td>X X</td>
<td></td>
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<td></td>
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<tr>
<td>4. Collaborative commissioning</td>
<td>X X</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Triple Aim</td>
<td>X X</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>6. Duty to Cooperate</td>
<td>X X</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>7. Care Quality Commission reviews of Integrated Care System</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
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<tr>
<td>8. Data sharing</td>
<td>X X X X</td>
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<td></td>
<td></td>
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<tr>
<td>9. Foundation Trusts capital spend limit</td>
<td>X X</td>
<td></td>
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<td></td>
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<tr>
<td>10. Competition</td>
<td>X X</td>
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<td></td>
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<tr>
<td>11. Provider selection and Choice</td>
<td>X X</td>
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<td></td>
<td></td>
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<tr>
<td>12. National Tariff</td>
<td>X X</td>
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</tbody>
</table>
Risks and mitigations

The Health and Care Bill includes a range of measures that were developed in collaboration with the NHS as part of the wider Long Term Plan proposals (1, 3-6, 8-11 in Table 1). These proposals have undergone wide stakeholder and public engagement, and the policies were informed by that engagement. NHS England and NHS Improvement also published a document exploring options for creating statutory ICSs, which informed the legislative underpinning for statutory ICSs which is now included in this Bill (2)\(^8\).

Other proposals considered in this IA, some of which were developed whilst the Covid-19 pandemic was ongoing, had more limited opportunities for public engagement and formal public consultation. However, DHSC worked closely with a range of stakeholders from across the health and care system to develop and refine these proposals, including but not limited to NHS England, the Local Government Association, the Academy of Medical Royal Colleges, NHS Providers, the NHS Confederation and a range of medical trade unions. A full list of stakeholders who were engaged prior to the publication of the White Paper is included in Annex C of that document\(^9\), and numerous additional stakeholders have been engaged on the Bill since then. Finally, the proposals in the White Paper have also been subject to two inquiries by the Health and Social Care Select Committee.

Therefore, whilst there remains an inherent risk as a result of a lack formal consultation with the NHS frontline, other health and care staff and patients, and the public, the substantial engagement undertaken should mitigate that risk. Further, in many cases, the exercise of the powers in the Bill will trigger duties to consult and would go some way to mitigate this risk (though this is not the case universally).

As with any legislation, there is an inherent risk that, in making changes to existing legislation, some of the problems which that legislation attempted to solve will, in part, re-emerge. The 2012 Act was designed in part to drive value by raising the importance of commissioning and competition in the system. The research associated with the NIHR evaluation programme\(^10\) (see Annex A for more detail), and the views expressed by the NHS through its Long Term Plan proposals, point to the conclusion that the improvements

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\(^10\) In 2014 the NIHR DHSC Policy Research Programme funded four projects under the Health Reform Evaluation Programme exploring different aspects of the new health and social care system following the Health and Social Care Act 2012. The four projects explored: the new NHS commissioning system, diversity of healthcare provision, the establishment and operation of Health and Wellbeing Boards, commissioning public health services. A full list of references for this programme of work is provided at Annex A.
envisaged as flowing from this approach did not materialise to the extent that was hoped. In particular, it became more difficult to drive value through the integration of services when they were organised in a more transactional form, provider by provider. The NHS has been able to adapt the current system to some extent to improve the integration of services and thus to deliver the associated benefits. The proposed legislation would take this further, and allow a balanced approach that gives weight to both competition and integration where there are clear patient benefits. In supporting the NHS to continue the journey towards a greater emphasis on integration, it will also be important for the Government to work with the NHS to ensure that the potential (albeit, it would seem, in recent years, largely unrealised) benefits of provider competition remain in view insofar as this is compatible with securing the benefits of integration.

Where risks relate more to individual proposals, they are largely not possible to quantify. As there may be benefits as well as costs arising from the change – and it was not possible, at least at this stage, to monetise how this balance will play out in practice. Before setting out the costs, benefits and risks of each proposal, a summary of the evidence surrounding collaboration, agility and accountability is presented for context to these proposals.

The case for working together and supporting integration

The demands on the health and care system are changing. As people are living longer, they are also living with more health conditions, with one in four adults now estimated to live with two or more morbidities\(^\text{11}\). As the care of people with multiple morbidities is often complex, this requires the interaction between many parts of the health system. These interactions will become more necessary as the burden of multiple morbidities increases, with number of people in England with four or more conditions predicted to double between 2015 and 2035\(^\text{12}\).

There is general agreement across the public sector (and across health systems internationally) that lack of alignment of services is inefficient in delivering services to the public and results in worse user experiences. This may “result in gaps for service users, provision may be duplicated, and citizens may be buffeted between several different agencies of service providers”\(^\text{13}\). The integration provisions within this Bill will allow for more joining up between health, social care and other public services to provide wrap-around care and support that meets individual’s needs.

In health and care, while there is mixed evidence on whether collaboration can provide cost savings in the delivery of services, there is consensus that collaboration between health and care organisations and the reduction of siloed working can and should go further. The evidence for this approach has been set out over an extended period, with collaboration occupying discussions around change in the NHS for many years. This is tied up in the debates around integration of care – although the two terms are sometimes used interchangeably, collaboration between organisations is arguably the catalyst enabling the delivery of integrated services to people.

There are mixed results on the impact of collaboration on definitive health improvements, and this prompts further consideration of the benefits of collaboration for structural cohesion, staff, and patient experiences. NHS Improvement has described collaborative approaches as ones which “can improve communication, save time, reduce duplication of effort, improve


working relationships and provide a better experience for people who use health and social care services.”¹⁴ National Voices (a coalition of charities who advocate for person-centred care) has also emphasised the benefits of integration, as facilitated by collaboration, for patients:

“Achieving integrated care would be the biggest contribution the health and care services could make to improving quality and safety. Patients, service users and carers want continuity of care, smooth transitions between care settings, and services that are responsive to all their needs together.”¹⁵

More recent publications substantiate this view of the broader benefits of collaboration for challenges such as workforce. NHS Providers (the membership organisation for the NHS hospital, mental health, community and ambulance services) has noted the benefits for system leaders in “coming together around a shared aim and recognising that organisations have commonalities which leaders can rally around to develop joined-up workforce solutions”, resulting in reduced competition for staff within the same system and more varied opportunities for individuals to move between organisations.¹⁶

The proposals in this IA are therefore evaluated against the impact which they will have on collaboration within the NHS and between the NHS and local government, considering both how they aid the Covid-19 response and recovery, and whether they provide longer-term benefits for patients, staff and the public.

The case for reducing bureaucracy

Evaluations of bureaucracy across the NHS have been a common theme of healthcare discourse in recent years, with these discussions accentuated by the 2012 Act reforms and how the system has adapted since these. As well as procedural bureaucracy around issues such as procurement¹⁷, this takes the form of bureaucracy within leadership structures, including how the various leadership organisations within the NHS can send multiple and sometimes conflicting messages to the system.

The new proposals are designed to be enabling and flexible, with a greater emphasis placed in empowering local leaders, recognising that where the legislative framework is too inflexible and prescriptive, it can quickly become a barrier to innovation.

In assessing how NHS structures could improve, the Lord Darzi Review of Health and Care in 2018 noted that “By creating a separate institution for each health system function, the 2012 [Act] has resulted in confusion at individual provider level, with competing priorities and instructions.”¹⁸ The report recommended many changes to simplify the NHS’s structures at a national and local level which are echoed in the proposals in this IA, including the merger of NHS England and NHS Improvement and simplification of procurement processes.¹⁹ This desire for simplification of the regulatory oversight of the NHS has been echoed in a survey


¹⁵ Ibid., p 14


¹⁷ Responses to NHS England’s engagement on the NHS Long Term Plan were particularly high in relation to procurement rules (section 75 of the Health and Social Care Act 2012), due to an external online campaign. Of those that responded through the consultation directly, 76% of respondents agreed or strongly agreed section 75 should be revoked.


¹⁹ Ibid., pp 51-52
of NHS Trust leaders run by NHS Providers, which identified problems in this area as follows:

“Trust leaders tell us they are optimistic about the potential for new oversight frameworks to hold systems to account for collective performance, and for the alignment of system oversight with regulatory requirements at an organisational level. However, in the absence of legislative change, it will be complex for the national bodies and regulators to reconcile regulation and oversight at organisational level with the policy ambitions for collective accountability at system level.”

However, there is evidence from the response to extreme events – which has been extrapolated to the Covid-19 response – that there is a balance to be struck in managing these responses between agility and discipline. The King’s Fund has noted that: “The problem is that extreme events present unforeseen conditions and problems. They often require decisive action from central controllers. But they also require adaptation, creativity and improvisation on the ground.”

There is therefore evidence to suggest that a simplification of regulatory oversight, as enabled by legislative change, is desired by the system. However, at this point this should be balanced against the ongoing demands of Covid-19 on the system and a need for some elements of stability to be maintained. The proposals in this IA will therefore be considered against this caveat.

**The case for ensuring accountability and enhancing public confidence**

The World Health Organisation describes how the circle of accountability helps to reduce health inequity (Figure 1). The accountability proposals assessed in this IA are meant to work as a logical counterpart to the NHS’s longer-term activities, and particularly those developed under the Long Term Plan which provides a ten-year strategic view of NHS activity. Following the implementation of enabling laws and policies in the Health and Care Bill, long-term analysis of these mechanisms should include evaluation of the legislation both within government and with other stakeholders.

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![Diagram of the circle of accountability to drive health equity](https://example.com/diagram.png)
The importance of accountability in the administration of public services, and particularly health and care services, is also recognised as a key objective for governments. The World Health Organisation (WHO) has prioritised work with European Member States to strengthen their health systems through improved accountability following the adoption of the Tallinn Charter. At the outset, this approach assumed that strengthened accountability would lead to increased transparency and efficiency. However, when evaluating several countries’ approaches, it found that:

“the process of institutionalizing new processes and protocols aimed at improving health system accountability involves much more than simply specifying new mandates and enacting legal and regulatory frameworks. Institutionalization also requires investing in capacity building and attention to demand generation in order to promote sustainability.”

This suggests that accountability in the provision of health and care services relies upon, in the first instance, the legal basis of accountability within the NHS as a necessary framing context. However, the relationships which emerge from these arrangements also have an important role to play in ensuring accountability. Prior to the implementation of the Health and Social Care Act 2012, the King’s Fund noted the importance of this for two roles changed by the reforms:

“We have also identified a number of relationships whose characterisation will ultimately depend on the way in which the account holders interpret their powers and choose to exercise them. This seems to apply to two roles in particular: first to that of the Secretary of State, who has potentially significant powers over the NHS Commissioning Board and [CCGs] but has committed politically to less central intervention in the service; and second to that of the NHS Commissioning Board – its choice of a lighter or heavier approach to performance management when performance assessing [CCGs] will have a significant influence on the culture of the system as a whole.”

It can be inferred that a similar principle will apply to the proposals affecting accountability considered in this IA, and so these should be considered against the degree of relationship building needed to make them effective. This also goes some way towards explaining why quantifying the impacts of these policies is challenging. As outlined in this IA, the effect of the accountability proposals in the Health and Care Bill will depend upon how these new powers are exercised. This diminishes the prospect of a robust a priori analysis on how the proposals will affect the system. Furthermore, at present, the Secretary of State can formally use his direction powers to intervene only if the system is actually failing or at risk of failing. This is arguably too late a point to intervene and is a high threshold to pass. The measures ensure that the legislative framework contains updated and proportionate levers for the Secretary of State to set the strategic direction for the system and intervene as required to ensure that strategic vision is being delivered, via a more flexible mandate-setting process and powers of direction.

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23 Ibid., pp 51-52.

Post Implementation Review

The Department of Health and Social Care is committed to reviewing the policies that it implements. The exact details of the PIR for the proposals in this IA have not yet been planned and will be set out at implementation of the Bill, following the introduction of secondary legislation. In particular, this is because many of these proposals are enabling powers and the details of the final policy will not be finalised until the secondary legislation stage. This means that the specific plans for the PIR cannot be finalised until the final form of the policy, and the specific outcomes it is likely to affect, are known. Initial planning for the PIR is currently underway. Any review relating to the measures analysed in this IA should refer to the three core guiding principles. For example, a review may examine the effectiveness of establishing Integrated Care Systems in law at encouraging integration in the health system, and, encouraging effective commissioning of health services for patients.

Summary of the costs, benefits, risks and mitigations of each proposal

This section provides details of each of the proposed changes to support the health and care system. A summary of benefits, costs, risks and mitigations for each proposal is given within the context set out in the previous section.

1. Merging NHS England and NHS Improvement

Proposal summary

NHS England, and NHS Improvement (comprised of Monitor and NHS Trust Development Authority) have been operating as a single entity to the extent that current legislation allows since 2018. DHSC intend to legally merge the functions of the three main statutory bodies (NHS England, Monitor and the Trust Development Authority) responsible for the NHS into a single statutory body. Monitor and the Trust Development Authority will then be abolished. This merged body – referred to as NHS England and NHS Improvement in this IA - will have one board and one Chief Executive, and the organisation will be accountable to the Secretary of State. The new organisation will remain a Non-Departmental Public Body. This is intended to provide better aligned priorities and efficiencies, and a legal structure that better reflects how the two organisations already work together.

The public see the National Health Service as a single organisation. Parliament expects the whole of the NHS to work together to make the best use of its collective resources for the greatest benefit for patients. Health and care organisations are increasingly working together to improve care for their populations and want the national leadership to speak with a single voice. As the organisations with most responsibility for setting the direction of and overseeing the NHS, NHS Improvement and NHS England are already working closely together to align operating models, Board and committee arrangements, and appointments through the joint working programme.

Despite the progress made by the joint working programme to date, there are limits to what can be achieved under the current statutory framework. NHS England, Monitor and the Trust Development Authority have been assigned some distinctive and non-shareable functions, and primary legislation requires separate board governance, chairs and CEOs for the three organisations, even though they are attempting to operate a single leadership model. Furthermore, due to statutory commissioner and provider duties, the organisations still need to have: separate Audit and Risk Assurance Committees; separate Nominations and
Remuneration Committees; separate statutory committees; separate statutory accounts and financial allocations.

Although staff policies and terms and conditions can be aligned, the bodies also remain three separate employers – so, for example, to enable directors to exercise the functions of all three bodies they must be jointly appointed and employed by all three bodies (which complicates the employment arrangements). Internal finance involves some complexity in managing three separate budgets and ensuring the correct allocation of funding between the three bodies, while aiming to act as a single organisation.

Costs
Merging organisations can come with associated costs in the short-term including: redundancy packages arising from reducing head count for duplicated functions; transitioning multiple IT systems; transitioning multiple office locations. An attempt to quantify these operational costs has not been made as the merger of NHS England, Monitor and the Trust Development Authority is already largely complete and so any such costs would have been borne previously. The legal merger will be formalising the effective merger that is currently in operation but will remove the need for workarounds generated by the existing legislative framework.

Benefits
The merger will formally create in law a single body responsible for the oversight of NHS commissioning and provision. This will create a more empowered, streamlined NHS England, and clearer lines of accountability for the bodies underneath it. It will align a more integrated national landscape with more integrated local systems, bringing commissioning and provision closer together to support strategic decision making.

While the joint working programme represents progress, forgoing legislative changes would leave the national bodies operating under complex joint arrangements and managing the unresolved inconsistencies and potential conflicts which arise from the original legislative framework for the three statutory bodies. Changes to the legislation will catch up with the agreed direction of travel at national and local levels. This will have the benefit of tidying up corporate governance and clarifying accountability to government and parliament.

Merging organisations can come with associated benefits in the long-term, in particular through a reduction in duplicated functions which may result in reduced overheads. An attempt to quantify these benefits has not been made as the transition to one single organisation is largely complete.

Risks and mitigations
The formal merger of NHS England and NHS Improvement has limited risks, as the joint working programme is already largely complete. There is potential for conflicts of interest to arise within the merged organisation where there is not an alignment between NHS England’s commissioning functions and the regulatory, support and oversight functions. This is expected to be mitigated through governance arrangements which maintain appropriate separation between functions and manage conflicts of interest, and by statutory guidance and new powers of direction from the Secretary of State. In particular, the Care Quality Commission remit, as the independent regulator of health and adult social care in England, will remain unchanged.

Important note
Other proposals considered in this IA make reference to NHS England and NHS Improvement – this is a reference to the merged organisation combining the functions of
NHS England, Monitor and the NHS Trust Development Authority as set out in the existing legislation. References to NHS England, Monitor or NHS Trust Development Authority on their own should be interpreted as referring to their associated specific functions under existing legislation.

2. Establishing Integrated Care Systems in law

Proposal summary
This proposal will enable the creation of Integrated Care Boards and Integrated Care Partnerships 25 (together “ICSs”) on a statutory footing, to cover the whole of England. ICSs are intended to provide a forum for strategic planning and decision-making for the NHS. NHS England and NHS Improvement have recently consulted on the next steps to building strong and effective integrated care systems across England, which closed on 8 January 2021. 26 The consultation document outlines that amongst representative bodies, overall, there was a high level of support to consider establishing ICSs in statute.

Following this consultation and extensive discussions with stakeholders, our proposal is that an ICS will be formed in each ICS area. These will be made up of a statutory Integrated Care Board (ICB) and a separate Integrated Care Partnership (ICP), bringing together the NHS, Local Government and partners. As of April 2021, all areas of England are under the remit of a voluntary ICS, as was outlined in the Long-Term Plan 27. Therefore, this proposal will formalise and develop the arrangements already in place on a voluntary basis.

Integrated Care Boards (ICBs) will merge the functions currently being fulfilled by voluntary ICSs with the functions of a Clinical Commissioning Group (CCG). The role of CCGs as stand-alone entities will be abolished in legislation; in practice, it is expected that most CCGs will already have transitioned into an ICB role. Statutory ICB functions will, in particular, include:

- Developing a plan to meet the health needs of the population within their defined geography; and
- Securing the provision of health services to meet the needs of the defined geography’s population (including capital plans for all trusts in the ICS).

Each Integrated Care Board will have a board to make day to day decisions. The board will, as a minimum, include a chair, the CEO, and representatives from NHS trusts/NHS foundation trusts, primary care, and local authorities, and others determined locally. ICBs will also need to ensure they have appropriate clinical advice when making decisions. NHS England are expected to issue guidance on the membership for ICBs.

Integrated Care Partnerships will be made up of a wider group of organisations than the ICB. It will be a joint committee rather than statutory body. This Partnership would be tasked with promoting partnership arrangements, and developing a plan to address the health, social care and public health needs of their system. Each ICB and Local Authority would have to have regard to this plan. The Partnership will be promoting collaboration and it would not impose arrangements that are binding on either party, given this would cut across existing Local Authority and NHS accountabilities.

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Putting ICBs on a statutory footing is necessary because there are legislative constraints on the ability of organisations within a voluntary Integrated Care System to make decisions jointly. While systems have found ways to establish effective governance models, obstacles and limitations in the current legal framework remain. For example, there is no legal basis at present for CCGs, NHS trusts and FTs to form a joint committee to which functions may be delegated and which makes decisions on behalf of the members. In order for volunteer Integrated Care Systems to progress further, legislative change is now required to give ICSs stronger and more streamlined decision-making authority, and to embed accountability for system performance and delivery into the accountability arrangements of the NHS to Government and Parliament.

**Costs**

ICBs and ICPs will merge some of the functions currently being fulfilled by non-statutory Sustainability and Transformation Partnerships and Integrated Care Systems with the functions of CCGs. These reforms therefore build on and cement the arrangements which the NHS and local partners have been evolving towards for several years, with different parts of the country having moved at different speeds. It is intended that the legislation will reinforce and speed up implementation of these arrangements. However, it is difficult to ascribe specific monetary figures to the scale of overall savings from this approach, particularly as the movement to the new system has evolved over time, rather than at a particular date from which up-front costs can be attributed. Given that the Bill in part formalises what is already in place, and voluntary Integrated Care Systems are already up and running, many of the specific costs faced by new ICBs have already been borne.

The formal abolition of existing CCGs, and the subsequent merger of voluntary ICS and CCG structures can bring opportunity costs in the form of business disruption, potential relocation and new IT infrastructure. The integration of the NHS with other organisations (such as local authorities) may add complexity which would need to be carefully managed at a local level with respect to accountability and governance. However, the CCG merger programme has already reduced the number of CCGs to 106, from 213 in March 2013 and CCGs have been working ever more closely with local authorities in recent years, we expect these costs to have already largely occurred.

As there will be fewer statutory ICBs (~42) than the current number of CCGs (~135), the number of CCGs transitioned to a statutory ICB will be reduced leading to potential costs with limited numbers of very senior staff redundancies. It is hoped, however, that the proposals minimise the impact of organisational change on staff. NHS England have made a continued employment promise for staff carrying out commissioning functions, with a commitment not to make significant changes to roles below the most senior leadership positions. Furthermore, it is expected many of these costs are sunk costs, already absorbed in the existing CCG merger programme – the NHS Long Term Plan characterised every volunteer Integrated Care System as needing streamlined commissioning arrangements, typically involving a single CCG for each area. As of July 2020, 104 CCGs had merged into 20, with the remaining 115 CCGs being supported to transition by April 202128. NHS England have also committed that the vast majority of CCG staff will transition to roles in the ICB.

There may also be costs incurred for NHS England and NHS Improvement in assessing statutory ICBs. However, given that this proposal only formalises arrangements which should already be in place, it is expected these costs should be minimal.

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There will be administrative costs from running statutory ICSs, although it is difficult to assess whether these costs will be higher or lower than running the current non-statutory system. Firstly, administrative or running costs will vary between ICSs and will be somewhat dependent on how the ICB is structured internally. For example, some ICBs may require more place-based structures than others, and so calculating as a meaningful ‘average cost’ (which may be summed across the system to estimate a total potential administrative cost) based on systems that have already transitioned cannot be calculated. It will be incumbent on each ICB to make sure that its costs are proportionate and beneficial for the work they will be undertaking. Secondly, under the proposed system, ICBs will take on further responsibilities in addition to CCGs current remit, meaning that the running costs of CCGs and ICBs are not comparable. This means current CCG administrative cost data cannot be used as a counterfactual to compare to ICB administrative costs.

A government amendment has been passed which would mean that the ICB is prohibited from appointing someone as a member if they consider that the appointment could reasonably be regarded as undermining the independence of the health service because of the candidate’s involvement with the private healthcare sector or otherwise. We expect this to prevent, for example, directors of private healthcare companies, significant stakeholders of private healthcare or lobbyists from sitting on a board of an ICB. This amendment is not expected to have any significant costs on businesses. While private providers are not allowed to sit on ICBs, they are allowed to sit on ICPs. However, Integrated Care Partnerships will not make commissioning decisions or enter into arrangements that are binding or make decisions about funding allocations, these are functions conferred on the ICB. Therefore, the membership of individuals from private providers on this integrated care partnership does not present a conflict of interest in that way. A risk of this approach may be that private provider views are not taken into account when decisions are made on ICBs, thus reducing the quality of commissioning. However, this risk is mitigated by the legal requirement that ICBs must have due regard to the strategy of the ICP which will have private provider views taken into account.

Benefits

The proposal formalises the way in which local partners already collaborate with each other, providing a clear standard for each ICS area and creating a mechanism for ICS partners to make jointly binding decisions for the benefit of their local population. These will both enhance collaboration within systems by ensuring that ICBs can work together to progress on individual goals, and if these involve compromises, they must be to the satisfaction of all members.

Furthermore, a prescribed membership makes health and social care equal partners within the Integrated Care Partnership, as well as involving Local Authorities on the ICB, something which has not been necessarily the case with the informal arrangements used so far. As well as the need for NHS and local government collaboration being demonstrated by the experience of Covid-19, the Health and Social Care Select Committee, when previously examining NHS England’s proposals for legislative change, emphasised that “Local authorities must be part of the decision-making process in order for integrated care systems to be truly place-based and focused on population health.”

By enabling local authority participation at every level of the ICS this proposal aims to ensure that the plans they develop reflect the full health and care needs of each population, as well as driving integration through pooled budgets and joint working arrangements.

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Risks and mitigations

The primary risk attached to this proposal is that it does not strike the right balance between improving service and system integration and avoiding an excessive NHS restructuring. Stakeholders have repeatedly argued that a fundamental restructuring of the NHS is not wanted by the system at this point. Research associated with the NIHR evaluation programme points out:

“The changes embodied in the HSCA12 were complicated and far-reaching. […] The fragmentation of commissioning responsibilities was experienced as a particular problem, with […] complicated ‘workarounds’ required to manage the new complexities. There was no clear evidence that the creation of CCGs as GP-led organisations had led to tangible improvements in commissioning, although both clinical and managerial respondents were enthusiastic about the role played by local clinicians.

The loss of Strategic Health Authorities as a regional tier of co-ordination was experienced as problematic. The exact impact of the changes was context-dependent, with local organisations responding to their particular local and historical contexts. Our study was completed before any impact of STPs had been felt, but our findings suggest that, without clear statutory roles and authority, the creation of new regional-level organisations will not automatically lead to improvements in commissioning, nor will it solve the problems that we have highlighted associated with fragmentation of commissioning responsibilities.”

The core mitigation to the problems presented by statutory ICSs is to keep the mandated elements of their functioning to a required minimum set of requirements, while allowing ICSs to go further if locally appropriate. NHS England and DHSC will also issue guidance on the operation of ICSs, covering issues such as the establishment of ICBs and ICPs, internal governance; interactions with regulators; decision-making processes; and dispute resolution. The Secretary of State will also be able to set out in regulations which functions can be delegated into an ICB. These safeguards intend to prevent the ICB from becoming overly bureaucratic, while enabling collaboration and ensuring strong accountability to the centre.

The abolition of CCGs, and the greater involvement of a wider range of providers and local authorities in resource allocation decisions, brings a formal end to GP-led commissioning at system level. There are potential benefits and risks from this. On the one hand, a NIHR research programme between 2014 and 2018 did not find clear evidence that the involvement of local clinicians in the commissioning of acute hospital services provides health benefits. Therefore, a potential benefit of the proposal may be that clinicians can better focus their resources where they add most value. Yet there is variation across the system, and there may be benefits associated with the involvement of local clinicians in the design and commissioning of primary, community and integrated care services, and, in

32 In 2014 the NIHR DHSC Policy Research Programme funded four projects under the Health Reform Evaluation Programme exploring different aspects of the new health and social care system following the Health and Social Care Act 2012. The four projects explored: the new NHS commissioning system, diversity of healthcare provision, the establishment and operation of Health and Wellbeing Boards, commissioning public health services. A full list of references for this programme of work is provided at Annex A.
33 In 2014 the NIHR DHSC Policy Research Programme funded four projects under the Health Reform Evaluation Programme exploring different aspects of the new health and social care system following the Health and Social Care Act 2012. The four projects explored: the new NHS commissioning system, diversity of healthcare provision, the establishment and operation of Health and Wellbeing Boards, commissioning public health services. A full list of references for this programme of work is provided at Annex A.
fostering better relationships between commissioners and local providers. A risk of this proposal would be that the potential benefits of GP-led commissioning are lost. To mitigate this risk, ICBs will be expected to involve clinical expertise at every level. This proposal allows clinicians the flexibility to target their efforts more usefully.

The consultation run by NHS England and NHS Improvement, which ended in January 2021, found that of the 1,747 respondents who answered the question “Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?”: 49.2% agreed or strongly agreed with the proposals; 43% disagreed or strongly disagreed; and, 7.8% of respondents were neutral towards the proposal[34]. The document qualifies that there was a high level of support from most representative bodies, and, a strong appetite to integrate care and improve population health. The overall message was that of support, but with caution. As such the ICS proposals account for these consultation responses and aim to generate minimal disruption in the integration of health and care. The impact of the proposals will be fully evaluated as part of the post implementation review.

Important note
Other proposals assessed in this IA make reference to CCG functions or commissioning functions – these are the functions and powers associated with Clinical Commissioning Groups under present legislation but that will be migrated to statutory ICBs. Any references to CCGs should also be interpreted as referring to their associated specific functions under existing legislation.

3. Joint Committees and Joint Appointments

Proposal summary
Legislative proposals in this chapter set out a range of measures to support closer working within statutory ICBs and between NHS providers (NHS trusts and foundation trusts) to support the implementation of integrated care and other collaborative arrangements locally.

The proposals covered in this chapter are:

3a. To allow ICBs (in particular, commissioning functions) and NHS providers to create joint committees. This includes creating provisions relating to the formation and governance of these joint committees and the decisions that could be appropriately delegated to them; and allow NHS providers to form their own joint committees. Both of these types of joint committees could include representation from other bodies such as local authorities, primary care networks, GP practices or the voluntary sector.

3b. To introduce a specific power to issue guidance on joint appointments, with a view to providing greater clarity on such appointments across different organisations.

These proposals complement the commitment to have statutory ICBs and ICPs that bring together commissioners, trusts, primary care networks, local authorities, the voluntary and community sector and other partners.

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Costs
Allowing the flexibility for ICBs and NHS providers to create joint committees or to make joint appointments has no direct cost. The legislative change will enable local organisations to move to this way of working if deemed to be locally beneficial and appropriate.

Benefits
This proposal would increase the ease with which providers and commissioners could establish joint working arrangements and support the effective implementation of integrated care. Commissioners and providers currently have to use workarounds with complex governance arrangements in order to jointly discuss integrated care, incurring legal risk and administrative cost. This proposal would remove those costs for organisations that move to this way of working, where deemed to be locally beneficial and appropriate.

Joint appointments of executive directors can help to foster joint decision making, enhance local leadership and improve the delivery of integrated care. They can also help to reduce management costs and engender a culture of collective responsibility across organisations.

Risks and mitigations
A potential risk of moving to closer working is a lack of accountability and transparency in local decision making at organisational level. However, mitigations of this are set out below, and as such, the risk is judged to be low. The NHS Long Term Plan already specifically described existing voluntary ICSs as needing to be transparent and publicly accountable. New guidance will set out how joint committees of commissioners and providers will achieve this and will cover matters including membership of joint committees, their formation, procedures to be followed when making decisions and functions which should not be exercised by a joint committee.

Each organisation will retain its accountability for its individual actions. NHS England may in future, monitor and set expectations for the ICB under the performance framework.

When making joint appointments, there is the potential for conflicts of interest. The Bill will allow NHS England to issue statutory guidance that can describe the criteria that organisations should use to assess whether a joint appointment should be pursued, including whether effective arrangements to manage the conflicts of interest could be put in place. DHSC also expects to revise existing guidance on conflicts of interest to ensure that issues specific to joint appointments are captured.

4. Collaborative commissioning

Proposal summary
Many local areas are exploring ways of working more collaboratively and are seeking to align decisions and pool budgets between CCGs and NHS England and NHS Improvement, across CCGs, and between CCGs and local authorities (LAs). Existing legislative mechanisms make it difficult to do this in all circumstances, meaning local systems need to adopt complex workarounds to be able to make lawful decisions across a wider population footprint. In practice, these arrangements can be cumbersome, difficult to manage and can slow down decisions. With consequential amendments from the ICS reforms this issue will be transferred to the new ICBs (see section 2). It is therefore desirable to change the legislation to streamline and strengthen the governance for this type of decision-making.

NHS England has responsibility for directly commissioning a range of services, including primary medical care, essential and additional pharmaceutical services, dental care, certain public health (“s.7A”) services and specialised services. In a more integrated system,
commissioning of these services can be disconnected from wider pathways of care unless delegated to CCGs (which will become ICBs). This can lead to fragmented care, creating risks and issues in the system, and potentially resulting in a poor experience for patients.

Enabling ICBs to have more flexibility in who they commission services with and how will reduce the frequency with which services are commissioned in isolation of the wider care pathway, enabling greater integration of services, reducing fragmentation and improving patient experience. Although with ICBs taking on commissioning responsibilities there will now be one commissioner per system, the flexibility for ICBs to collaborate to commission services across several systems where appropriate is also crucial in ensuring good value and outcomes.

The proposals are:

4a. **Give NHS England the ability to allow groups of ICBs to collaborate to arrange services for their combined populations.**
4b. **Allow ICBs to carry out delegated functions, as if they were their own, to avoid the issue of ‘double delegation’.**
4c. **That groups of ICBs should be able to use joint and lead commissioner arrangements to make decisions and pool funds across all their functions.**
4d. **Enable NHS England to jointly commission s.7A public health services with one or more ICBs, or groups of ICBs or to delegate commissioning of these services to an ICB to carry out that function.**
4e. **Enable NHS England to enter into formal joint commissioning arrangements with ICBs including providing the ability to pool budgets in relation to specialised commissioning.**

**Costs**
The costs or savings from these proposals will depend upon how effectively NHS bodies and their partners are able to improve arrangement of their services. The primary legislation itself is expected to have no direct costs the proposals enable NHS England and ICB to change the way that they commission services. These proposals affect how NHS bodies work together to commission and arrange services, so an EANDCB has not been estimated.

**Benefits**
These proposals are expected to have several benefits. These benefits include: support multiple ICBs to collaborate and arrange services for their combined populations (4a, 4b), streamline decision making, saving time and resources for commissioners (4c); provide more local input into the commissioning of services (4d); and enable better focus on prevention and pathway design to support shorter length of stays for patients (4e).

**Risks and mitigations**
These proposals are enabling. Delegation will only happen on terms that NHS England and NHS Improvement consider appropriate. The Bill also provides specific safeguards to be introduced in secondary legislation where necessary. Specialised commissioning policy and service specifications will continue to be led at a national level, ensuring patients have equal access to services across the country.

5. **Triple aim**
Proposal summary
This proposal is that a new shared duty should be introduced that requires those organisations that plan services in a local area (ICBs) and nationally (NHS England), and NHS providers of care (NHS Trusts and Foundation Trusts) to have regard to the ‘triple aim’ of better health and wellbeing for everyone, better quality of services for all individuals, and sustainable use of NHS resources.

The aim of the shared duty is to enable closer working between organisations. It should be seen in the context of the other proposals set out in this IA as a supporting measure that will encourage and enable greater collaboration and integration of care.

In having regard to the triple aim, organisations will be expected to:
- Demonstrate compliance for example as part of the annual report, via board papers, or the website
- Consider the Triple Aim in their decision making
- Cooperate with others (most likely through ICBs they are already a part of)

Costs
In complying with the triple aim, it is possible that there is a financial opportunity cost to the individual organisation, as they take decisions that are for the greater good, rather than their own benefit. For example, one Trust may decide that it is in the best interest of the system that it closes a particular ward if there are others of the same specialism in close proximity. This may have a direct financial cost to the Trust but will provide a net benefit to the wider system and allow resources to be used more efficiently for patient care.

Furthermore, one of the three core elements of the Triple Aim is the sustainable use of NHS resources. This will mean that the bodies subject to the duty will demonstrate how they have had regard to the need for spending decisions to be measured and in the interests of the wider system, thereby limiting the costs associated with adherence to the Triple Aim.

Benefits
Under the current legislative framework, organisations work primarily in the best interest of their immediate patients and place significant emphasis on their duties as independent organisations.

The improvements in quality of care that are set out in the NHS Long Term Plan rely on alignment around a common set of objectives, a shared view of the challenges facing a system and a shift towards integrated systems of providers and commissioners.

The Triple Aim Duty encourages the bodies that are subject to the duty to work collectively, and in the best interest of not only their immediate patients, but of the wider population.

Given the supporting nature of this proposal it is not possible to quantify the benefit directly. However, as it is designed to reinforce other proposals, it is anticipated that implementing this change would make it more rather than less likely that successful integration of care will be delivered.

Risks and mitigations
This proposal enables and supports the potential effectiveness and benefits of other proposals in this Bill (e.g. more flexible financial arrangements). Thus, the benefits derived from this proposal will be depend on the success of the other measures to deliver beneficial system change. The extent to which the triple aim has an impact will also depend on the enforcement and implementation of the duty. NHS England and NHS Improvement has a
wide range of existing enforcement tools and guidance where the Triple Aim could be used to help facilitate organisational collaboration.

The creation of any new legal duty carries some litigation risk for the bodies that are subject to the duty. It is possible that the application of the new duty could result in additional Judicial Review challenges, where it is contended that a decision maker has failed to have sufficient regard to the triple aim in its planning or decision making. The wording of the duty has sought to mitigate the litigation risk. The duty is framed as one of “having regard” to “all likely effects” of a decision on the three limbs of the Triple Aim duty. Decisions concerning the treatment of individual patients are specifically excluded from the duty, thus removing one significant area of potential legal challenge. NHS England will be able to publish guidance on the Triple Aim, which will assist bodies in complying with the duty. Ultimately, where bodies are engaging in robust decision-making following proper engagement and consideration of the issues and system implications – the behaviour which the triple aim duty is designed to encourage – we consider that the risk of successful legal challenge to their decisions will be low.

6. Duty to cooperate

Proposal summary
The NHS 2006 Act contains duties to cooperate between NHS bodies, and between NHS bodies, on one hand, and local authorities on the other. It is the intention to strengthen these duties by enabling the Secretary of State for Health and Social Care to issue statutory guidance on what cooperation means in practice. English bodies subject to the cooperation duties, will have to have regard to the statutory guidance. The first cooperation duty applies to: NHS England and NHS Improvement (as a merged entity); ICBs; NHS Trusts and Foundation Trusts; Special Health Authorities; some arm’s length bodies such as NICE, NHS Digital and Health Education England. The second duty applies to interactions between NHS bodies and local authorities.

The existing cooperation duties have not proved enough to drive the system towards full cooperative working under normal circumstances. However, the response to Covid-19 has demonstrated the system’s ability to cooperate at pace during times of crisis, and many parts of the system are now looking to embed these changes in their ways of working through the remainder of the Covid-19 response and beyond. To ensure that these changes are not concentrated only in certain areas the guidance will make it clear to the entire system where cooperation is essential.

These proposals complement the commitment to have statutory ICBs (section 2) that bring together commissioners, trusts, primary care networks, local authorities, the voluntary and community sector and other partners.

Costs
While the legislation will not require organisations to be formally assessed on their adherence to the duty, there may be some reporting costs associated with organisations demonstrating application of this duty. The scope of these will depend on whether anything about reporting is set out in the subsequent guidance. Otherwise, costs associated with the addition of guidance to the duty to cooperate should be minimal, as this should impact primarily how organisations work rather than what they are doing.
Benefits
This change will strengthen the impetus for individual organisations to work together and requires them to consider how to cooperate effectively. However, it will also be flexible allowing organisations to implement cooperative working in ways which suit them. It will arguably provide a stronger and clearer signal to the system than is currently given through existing duties, making obvious what the system should be working towards out of necessity.

The duty also applies to local authorities, supporting existing joint working arrangements and creating a further binding connection between the work of the NHS and local government. This will reflect the importance of collaborative working and support the effective operation of statutory ICBs.

Risks and mitigations
This proposal enables and supports the potential effectiveness and benefits of other proposals in this Bill (e.g. appropriate joint working by ICBs). Thus, the benefits derived from this proposal will be dependent on the success of the other measures to deliver beneficial system change. The extent to which the duty of collaboration has an impact will also depend on its enforcement and implementation.

There is a risk that statutory guidance issued by the Secretary of State will not be a strong enough incentive for organisations to cooperate effectively across the system. However, as well as cooperation largely being in the best interests of the health and care system, this duty will complement the wider changes in the Bill which are intended to support system approaches and increasingly joined up working across the bodies that deliver health and care.

7. Care Quality Commission reviews of Integrated Care Systems

Proposal summary
The Care Quality Commission (CQC) is the independent regulator of health and social care in England. The Bill, following a recommendation from the Health and Social Care Committee, proposes a new role for the CQC in reviewing across each local Integrated Care System. These reviews will assess the provision of NHS, public health, and adult social care, the activities of the Integrated Care Board, local authorities, and providers in relation to that care and the functioning of the whole system including for example the Integrated Care Partnership.

We expect that these reviews will initially look at the themes of integration, leadership, and quality and safety. They will provide the public and the system with independent assurance of how their area is performing and in particular the effectiveness of joined up working and integration. This will complement the wider work in the Bill through providing an independent assurance of how effective systems are at working together and improving the care people receive.

The amendment also gives the Secretary of State a role in setting priorities and objectives and approving the indicators and methods, allowing the Secretary of State to ensure that these reviews align and complement existing assessments.

It is the intention that the CQC will work collaboratively to develop the approach to these reviews, and therefore the design of the inspection regime has not yet been finalised. DHSC worked with CQC to establish the potential impacts of this proposal.
Costs
It is not currently possible to make an accurate estimate of costs for CQC ICS reviews as the CQC has not at this time determined or tested the methodology. All 42 ICS would be subject to these reviews. Discovery work by the CQC will be undertaken to define the potential scope of the reviews, but until that work has been completed, the resources required to undertake reviews cannot be stated. There is no easily comparable activity we could use to estimate the costs. For example, the CQC’s Local Systems Reviews had a different scope and ICSs have a larger geographical footprint.

As an example of costs, for illustrative purposes only, it may be that there would be some implementation and familiarisation costs for the CQC in setting up the system of reviews. This may include new infrastructure to collect data or training staff to undertake the reviews. It is the intention to minimise these costs. There may also be cost on CQC resources as these reviews would be in addition to their existing responsibilities, although this may be mitigated as the reviews should aim to avoid duplication. These reviews will build on much of the evidence that the CQC already gathers through its ongoing regulatory activities of providers and as introduced in the Bill, local authority functions relating to adult social care. We expect that any new evidence gathered for these reviews may, for example, relate to system leadership and collaboration between system partners.

There may also be familiarisation costs for organisations in the system, as they will have to comply with any inspection requirements (as is the case for all health and care organisations registered with the CQC).

There may also be ongoing costs for organisations to comply. It is the intention to minimise these costs. As the dimensions that the ICS will be assessed against have not been finalised, it is not possible to give an accurate costing for each inspection. The CQC are due to consult on the nature of these reviews and due consideration for the impact of the reviews will be made at that point.

In terms of the funding for these reviews, the CQC has a statutory responsibility to consult on any changes to its fees scheme and an impact assessment examining the potential effect of fee changes would be produced at that point.

Benefits
This proposal, alongside a range of proposals in the Bill, will encourage system partners to work together as part of the Integrated Care System as a whole to deliver effective care. The reviews themselves will help improve systems by identifying their strengths and the challenges they face. Repeat reviews, with the ability to map progress against previous performance can themselves be an impetus for improvement. The CQC are also intending for these reviews to inform their reviews of providers and local authorities, thus it has the potential to enhance the CQC’s other regulatory work. Finally, the CQC reports will provide an independent assessment of how well areas are performing providing decision-makers and the public with information about the quality and care and joint working within each area. This has benefits in terms of greater transparency in the quality of care provided in ICSs.

Risks and mitigations
There are a range of oversight measures in the system including NHS England’s performance assessment of ICBs, and the CQC assessments of providers and the proposed local authority adult social care assurance. There is a risk of duplication, and, if they are not effectively aligned that there could be conflicting reports on the quality of performance.
The CQC will work collaboratively with NHS England and other system partners as they develop their methodology and approach. This is intended to minimise overlap and avoid inconsistency. As the amendment also gives the Secretary of State a role in setting priorities and objectives and approving the indicators and methods, the Secretary of State can ensure that these reviews align and complement existing assessments.

8. Data sharing

Proposal summary
The Bill proposes several main changes regarding the collection of data in the health and social care sector:

8a. Introduce powers for the Secretary of State to require information from all regulated adult social care providers about themselves, their activities connected with the services they provide in England (whether funded by local authorities or privately by individuals) and the individuals to whom those services are provided (in England or outside England where the services are commissioned by English local authorities). This will enable government to request data from the adult social care sector to assist with evolving situations, including Covid-19, plan for care provision and maintain oversight of the system. The nature of the information required may change over time.

8b. Enable health and social care public bodies to require the provision of anonymous information (i.e. information other than personal information) from other such bodies and from private bodies providing health and adult social care services under arrangements with such public bodies in connection with the provision of health services or adult social care in England.

8c. (i) Place a duty on NHS Digital to have regard to the need to (a) promote the effective planning, development and provision of health services and adult social care in England when exercising its functions, such as processing and sharing information, and (b) balance this and other needs to which it must have regard under section 253(1) of the 2012 Act with each other.
(ii) Clarify the purposes for which NHS Digital can disseminate information.
(iii) Enable NHS Digital to require information from private providers of health care (when directed to collect information by the Secretary of State). The current legal framework does not expressly cover (i) and (ii) and hence this is being clarified. The powers in relation to private health care providers will support a consistent and transparent approach to the processing of data across privately and publicly funded healthcare to support improved safety and quality of provision.

8d. Introduce a power for the Secretary of State to mandate standards for how information is processed (including how it is collected and stored) by health and social care providers, so that data flows through the system in a usable way and so that when it is accessed/provided (for whatever legitimate purpose) it is in a standard form, both readable by, and consistently meaningful to, the user/recipient. The power will enable the Secretary of State to apply such mandatory standards to private as well as public health and social care providers.

8e. Enable the introduction of regulations to impose financial penalties on private providers who, without reasonable excuse, fail to comply with an information standard, fail to comply with a requirement to provide information, or who provide false or misleading information.

The need for the new enabling power (8a) has become more prominent during the Covid-19 response, during which information has been provided voluntarily by social care providers.
and informed DHSC’s assessment of the risks and issues faced. Information provided has allowed a consistent approach to DHSC’s response and underpinned Care Home Support Plans. However, the data collected is not uniform, and there are gaps that impact on DHSC’s ability to proactively respond to provider risks. If this power is exercised it will provide ongoing oversight of the adult social care sector and inform policy development. This enabling power is intended to work in tandem with new power (8c (iii)) which allows information to be required from private healthcare providers, and new obligation (8b), which provides a clear statement of intent that where information can be shared it should be. Provision 8b will is intended to provide that anonymous data information that is already held by private health and social care providers can be shared as needed for the benefit of the health and adult social care sector. As set out below it will only be commenced following the introduction of regulations which will set out exemptions to the duty.

The new duty (8c (i) - (iii)) will clarify NHS Digital’s duty to have regard to wider matters namely the effective provision of health and social care, including treatment, diagnosis or assessment of needs, and also the effective planning and development of that care, such as population health management, risk stratification, audit, policy development, research, and commissioning of services. This, along with the duty to have regard to the need to balance the various needs to which NHS Digital must have regard, will clarify in law how NHS Digital’s duties under the 2012 Act must be exercised safely and securely, to ensure it are able to maximise benefits to the health and care sectors and those that use its service. The new power enabling NHS Digital to require data from private providers will support work to improve the quality and safety of private and NHS healthcare by developing a common set of standards for data collections, performance measurement methodologies and reporting systems across the NHS and private healthcare.

The power to mandate standards for how information is processed across the whole health and social care sector (including by private providers) (8d) aims to ensure standards can be set that improve interoperability of systems and effective data exchange. Existing legislation only requires providers to have regard to standards (though they would need a compelling reason not to do so) and only applies to public health and social care providers and private providers acting pursuant to arrangements with public bodies.

Costs
The following section will provide an indication of the costs that may materialise if these powers are exercised, or following the introduction of regulations. Overall, it is not possible to provide an EANDCB figure for these proposals yet as the details of how the proposals will be used or any exemptions or regulations have not been developed. However, the process would be kept under review as information needs develop and an EANDCB and SaMBA will be provided as part of an impact assessment once the details of how the powers will be used are finalised.

To provide an indication of potential impact on business, the section is split to discuss each proposal (8a-e) in turn, although the statistics in care market size and the number of small and micro businesses discussed in reference to proposal 8a will be useful context for other sections.

Proposal 8a
As at March 2021, there are 15,409 care homes (operated by around 6,500 different organisations) in the social care market, of which over 99% are registered with a voluntary capacity tracker administered by NHS England and NHS Improvement to support the Covid-19 response, and this has a 95% completion rate. In terms of proposal 8a, the details of the data which may be collected on a mandatory basis using these powers are yet to be
determined, and therefore a comprehensive assessment of future potential burdens placed on providers cannot yet be undertaken.

If, for example, the power were exercised and a requirement was placed on care providers (who may be private businesses) to provide information that they do not already collect, this may lead to an impact on the provider in terms of administrative costs. These costs may include; staff time to collect the data; costs to introduce and maintain IT to store data securely, including security software; familiarisation and training costs in terms of proper handling of data and use of new software for staff, and, staff time to collate and send the data in the required format.

Although the paragraph above gives an indication of potential costs, it is the intention to minimise any additional burden on (public or private) providers of care where possible. This is underlined by the intention to follow the below principles when determining how the powers will be used:

- Data will be collected once and shared with those who need it, to avoid national government and Local Authorities collecting the same data separately from care providers;
- Feedback will be sought from provider group representatives prior to finalising the details of any data collection;
- Frequency of data collection will be the minimum needed to meet data needs. During the pandemic the voluntary capacity tracker data collection was daily for some data items, however, it is likely that in a non-emergency situation most data will be needed monthly or less frequently.
- The collection of very granular data, such as detailed data on individual care users, will be kept to a minimum where such data are not held in digital format and therefore would present a significant burden on providers to submit manually.
- If individual level data are being collected, providers will not be expected to bear the burden of anonymising or pseudo-anonymising such data, rather this will be taken into account when identifying an appropriate data collection mechanism.

Any costs that may materialise cannot yet be quantified as details of how the enabling powers may be used have not been decided. At that point, an impact assessment and EANDCB will be produced as appropriate.

Defining small and micro providers as having fewer than 50 employees and using a ratio of 1.5 employees per bed, small and micro care providers can be defined as those having fewer than 33 beds in total. We define a provider using the provider ID field in the CQC care directory, and count brands as a single provider even if they have multiple provider IDs. As at April 2021 there are 3,785 such care home providers out of 6,485 in England, although they only represent 68,737 beds out of an England total of 458,955. However, some will not in fact be small and micro providers if they have a higher staffing ratio than 1.5 or if they have activity in other markets. It should be noted that the smaller providers are disproportionately likely to serve younger adults, where self-funder numbers are substantially lower, so will be less affected by the reforms. These numbers therefore represent an upper bound of the number of small and micro businesses. Therefore, small and micro businesses will not generally be exempt from the proposals because we need to collect data from across

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the whole sector in order to get the full picture of the social care market. For example, excluding small providers would significantly impact DHSCs ability to collect data on younger adult care homes, which tend to be smaller. It is not currently possible to state whether small and micro business will be disproportionately affected by the legislation until details of what data will be collected. It is plausible that small providers with little IT infrastructure or few staff may face a disproportionately high cost to collecting and storing additional data (as for example, increased workload on a small organisational workforce will have a greater proportional effect on resource constraints than on a large organisation). It is the intention that any additional costs will be minimised when exercising these powers, and that a small and micro business assessment (SaMBA) will be completed as appropriate and due consideration given to the need for exemptions.

**Proposal 8b**

The requirement for private providers to provide anonymous information is not intended to impose significant additional burdens on organisations to collect information; the intention is to enable organisations to be required to provide anonymous information they already hold, by a relevant organisation. Therefore, there are likely to be no significant additional burdens from collecting data that is not already held. The clause expressly provides that organisations cannot be required to process information to render it into a form in which it must be provided. This means that organisations will only be required to share information if they already hold it in a form that does not identify an individual, or, enable the identity of an individual to be ascertained. Any data held that is not in this form will not be subject to the requirement. Therefore, it is intended that providers will not be subject to any costs processing existing information to render it anonymous.

There may be an administrative cost on organisations required to provide information; for example, staff time taken to send the data across to the relevant public body. The Bill includes a power to make regulations to provide for exemptions to be introduced such as where the data is commercially sensitive. The power to require information will not be exercised until the regulations are in place and we will assess potential burden on providers and how we can mitigate these as part of the development of the regulations. Until the exemptions have been finalised, it is not possible to give a comprehensive assessment on the scale of impacts on businesses. In particular, this is because the number of private providers affected by them is not yet known. As an indication of the number of businesses potentially affected, one may refer to the social care market analysis presented in 8a. An EANDCB and SaMBA will be produced alongside the regulations as part of an impact assessment as appropriate to fully assess the impacts of the proposals, including on private providers who have not been captured by the market size statistics above.

**Proposal 8c**

In relation to 8c(iii) private health care providers are already required by the Competition and Markets Authority to provide information on the services they provide to the Private Healthcare Information Network (PHIN). NHS Digital is currently working with PHIN to ensure a common set of standards for data collections, performance measurement methodologies and reporting systems across NHS and private healthcare. The provisions in the Bill will support this work, a key strand of which is to identify where current and future burdens (for instance providers having to provide different sets of information for different services) can be reduced.

However, as with proposal 8a above if the power were exercised and a requirement was placed on private healthcare providers to provide information that they do not already collect, this may lead to an impact on the provider in terms of administrative costs. These costs may include; staff time to collect the data; familiarisation and training costs in terms of proper handling of data, and, staff time to collate and send the data in the required format. If these
powers were to be exercised, then an assessment of the potential costs and benefits, including an EANDCB and SaMBA would be completed as appropriate. As mentioned, when discussing proposal 8a, smaller providers may be disproportionately affected, which would be considered, along with any exemptions if these powers were exercised.

These are enabling powers and it is not therefore possible to quantify what, if any, burden may be imposed on private healthcare providers. The potential additional burden on private organisations will be reviewed as part of the development of any directions to NHS Digital made under section 254 of the Health and Social Care Act 2012, which would enable NHS Digital to require information from private providers.

Administrative costs to NHS Digital associated with the changes we are making to its functions and powers (points 8c(i) and (ii)) are expected to be limited as the new legislation is intended to provide clarity on NHS Digital’s key duties and the purposes for which it may share information rather than to impose additional requirements on it.

Proposal 8d
This proposal introduces a power for the Secretary of State to mandate standards for the processing of information (including how it is collected and stored) by health and adult social care providers. Information standards are already applied to providers of publicly funded health services and adult social care and they are expected to comply with them. Compliant providers should therefore have budgeted for the cost of compliance with information standards. However, the proposed legislation provides that information standards may also be applied to private providers, enforced by financial penalties, and they may therefore incur new costs. These costs on private providers of healthcare may be in terms of the cost of processing data in accordance with the standards.

Costs of processing data in line with information standards may include increasing staff time and updating IT systems to process data in the correct format, ensuring the data is securely stored, and available to the appropriate recipients. It is not possible to quantify the scale of these costs as the scope of these requirements have not yet been finalised. If these powers were to be exercised, then an assessment of the potential costs and benefits, including an EANDCB and SaMBA would be completed as appropriate. As mentioned when discussing proposal 8a, smaller providers may be disproportionately affected, which would be considered, along with any exemptions if these powers were exercised.

Regulations will set out the procedure for preparing and publishing information standards and this is intended to ensure that new standards set are reasonable and achievable and it is expected that providers will factor in the cost of meeting them.

Proposal 8e
This provision enables the Secretary of State to make regulations to enable the imposition of a financial penalty on private providers who without reasonable excuse, fail to comply with an information standard (provision 8d) or who fail to comply a requirement to provide information under provisions 8a, 8b, 8c(iii) or who provide false or misleading information under those same provisions.

This may impose costs on businesses, although a robust figure as to what this cost may be is not possible to estimate as details of these penalties, if imposed, would be finalised at secondary legislation stage. Furthermore, compliance is difficult to estimate, in particular, without knowing full and final details of the data requirements.
Benefits
Benefits from all proposals are indirect and, except 8b, depend on the actions of NHS Digital and/or the Secretary of State. Nonetheless, clarifying that information may be disseminated for wider purposes which would include the wider health and adult social care system will enable NHS Digital to make better use of data it currently collects. On the other hand, implementing power 8a will strengthen the Secretary of State’s oversight of social care provision, ensuring that the right level of capacity and support is available to ensure service continuity. Over time it should contribute to parity of information available from health and care providers. In addition, 8c(iii) will support improved safety and quality across private and NHS health services.

Improving the enforceability of standards (8d) will strengthen the negotiating position of officials dealing with non-compliant health and adult social care providers.

Risks and mitigations
The primary risk identified for this proposal is that, at the present stage, there will not be any processes in the legislation which will require new requests for information to be evaluated or for the overall burden on NHS Digital and health or social care providers to be periodically reported and reviewed. However, it is expected that this will take place in practice to ensure any new risks from the collection of data are identified and suitable mitigations are implemented.

The data provisions, which would be enforceable, may be seen as risking the creation of onerous legal duties on health and care system providers. We will seek to consider and mitigate this including as part of the development of regulations under these powers, which are subject to the affirmative procedure in Parliament. For information standards it is expected that this risk will be mitigated by a thorough statutory procedure for preparing and publishing new standards, based on the current procedure, which it is intended will include consultation with stakeholders, and which aims to ensure that standards are proportionate and fit for purpose. A robust, regular review process will also be implemented to ensure that standards are kept up to date and there will also be a waiver system that will allow providers to apply for a temporary or long term waiver from complying with an information standard in circumstances set out by the Secretary of State.

9. Foundation Trusts capital spend limit

Proposal summary
This proposal will give NHS England a targeted, reserve power to set annual capital limits on individual, named NHS foundation trusts (FTs). One of the current barriers to developing a more collaborative approach to planning capital investment is that, whilst Parliament approves an annual financial envelope for capital expenditure across the Department of Health and Social Care and the NHS, and NHS England set capital spending limits on individual NHS Trusts, there are no mechanisms to do the same for NHS foundation trusts.

NHS England and NHS Improvement have explored voluntary approaches to address the need for capital controls across providers, but given the lack of proportionate legal mechanisms to require solvent NHS foundation trusts to adhere, there is a risk that these will be unsuccessful in protecting the NHS’s overall capital limits. The Bill therefore proposes that there should be a targeted, reserve power for NHS England to set capital limits on NHS foundation trusts. It is expected that this power will be used only in cases where there is a clear risk that FT spending plans could breach their local system capital.
envelope, and as a last resort, for a specified period, for individual FTs. NHS England is not expected to use it to impose capital expenditure limits on the vast majority of FTs.

This proposal does not create a direct cost to the system as a whole, as the capital spending envelope remains constant across the NHS. It will also be supported by the requirement that each ICB and partner NHS trusts/FT develop a Capital Spending Plan to target its capital spend strategically across the system. This is also expected to result in a more collaborative approach to capital spending.

**Costs**

As this is an enabling power it is not expected that there will be any direct costs from the proposal. It should be acknowledged that, if the power were to be exercised, imposing a capital limit changes the freedom which FTs were previously given to make capital investment decisions.

**Benefits**

As part of the Long-Term Plan’s ‘Five Tests’, the NHS outlined a commitment that the NHS will make better use of capital investment and its existing assets to drive transformation. Part of the justification for this test is the urgent need to invest in the buildings and facilities of the NHS to meet the demands of a modern health service. This proposal will attempt to create balance between unpredictable capital costs; the high-priority spending which also needs to be addressed; and lower-priority capital projects which require longer-term planning to be met.

Applying the control would mean that the FT investment foregone is available to other NHS organisations with a fairer distribution of capital to enable investments with higher need and achieving greater benefits to staff and patients.

**Risks and mitigations**

NHS foundation trusts may in future incur costs to secure commercial loans, which they may be unable to spend due to the imposition of a capital limit.

A further risk is that beneficial capital investment in the Foundation Trust sector, including reinvesting their own capital, may be prevented or disincentivised. This could take the form of deterring Foundation Trusts from pursuing innovative approaches to estates redevelopment.

A further example is if a FT is faced with a potential capital limit in the following year, the FT may delay starting a project in the current year because any costs running into the following year (whether because it’s a long term project or unforeseen delays) could breach the capital limit. A potential cost of this would be to delay getting the benefits for a further year, likely cost increases due to inflation, or, backlog maintenance issue getting progressively worse so that more investment is required to fix them.

These will need to be mitigated by clear expectations on how NHS organisations and systems should approach their capital plans in the long-term and assign the limited capital funds to where they can achieve the greatest benefits to staff and patients. In addition, it remains the aim of the Department to receive a multiyear capital settlement to provide more certainty on future resources and support better long-term planning.

10. Foundation Trusts capital spend limit
Proposal summary
The proposals in this group intend to change the roles in respect of competition of the Competition and Markets Authority (CMA) and NHS Improvement (Monitor functions), to create a more nuanced approach to certain NHS transactions that gives greater weight to collaboration (while still recognising the value of competition).

The proposals in this section are:

a. **The CMA’s function to review mergers involving NHS foundation trusts should be removed.** Instead NHS Improvement (NHSI) would continue to review proposed transactions, including mergers or acquisitions, to ensure there are clear patient benefits.

b. **NHSI's competition powers and duties should be removed.**

c. **The need for NHSI to refer contested license conditions or Tariff provisions to the CMA should be removed,** along with the provisions that prohibit NHS Improvement from proceeding with a National Tariff publication if the proportion of relevant objections reach a certain threshold.

Current legislation requires Trusts that are considering a merger to engage with the CMA’s merger regime, if at least one is a Foundation Trust. This can be a time-consuming and complex process with significant resource requirements. In practice, the CMA has reviewed about one NHS merger per year since 2013, although it is likely that increased collaboration in the NHS may lead to more mergers. It should also be noted that the CMA has only blocked one merger (in 2013), and that this merger was subsequently allowed. It is also unlikely the CMA would block any mergers that were presented correctly, and which focused on demonstrating the patient benefits that would accrue as the result of such a merger.

The CMA is supportive of this change in legislation.

Powers to enforce the Competition Act 1998 and Enterprise Act 2002 in relation to the provision of healthcare services in England (‘concurrent powers’) were conferred on NHS Improvement (as Monitor) by the Health and Social Care Act 2012. The Act also gave Monitor a general duty to prevent anticompetitive behaviour where it was not seen to be in the interest of patients.

As explained by the Health and Social Care Committee in their 2018 Integrated Care report, “[T]he then Secretary of State for Health, told our predecessor Committee in 2011: What we are doing, through amendments to the legislation, is to make it absolutely clear that integration around the needs of patients trumps other issues, including the application of competition rules. However, despite that reassurance, reforms to extend the NHS internal market, including the role of competition, have impeded rather than supported services to integrate.” The proposals in the Health and Care Bill give a renewed focus on encouraging greater integration between care providers, and therefore the retention of general concurrent powers to enforce competition law, whilst simultaneously promoting integration, would create mixed messages for providers, as competition is perceived as conflicting with a drive towards integration. The removal of NHSI’s concurrent powers will signal to providers that collaboration and quality should be the organising principles that underpin the planning and delivery of NHS care. Competition will still play an important role in driving improvement in NHS-funded healthcare, for example, through competitive procurement exercises and patient choice. The removal of NHSI’s concurrent competition powers is to reflect NHS England’s primary role to support improvement in the quality of care and use of NHS resources, rather than as an economic or competition regulator.


37 Ibid.
The CMA’s statutory role allows it to conduct regulatory appeals and redeterminations in relation to price controls or terms of licences, although it is not clear that it has the expertise and insight into NHS services to be the appropriate holder of this role. Removing the relevant CMA powers will ensure that decisions are made in the interests of the NHS as a whole will and minimise the risk of delays to decisions and to National Tariff publications.

**Costs**
Costs will depend on future decisions about alternative regulatory arrangements (9a & 9c) and any future change in the propensity to judicially review contested licence conditions which can currently be referred to the CMA (9c). Any benefits associated with the duty to prevent anticompetitive behaviour will also be forgone.

**Benefits**
The benefit of these proposals will be to enable integrated care across foundation trusts and to reduce the administrative cost of any future mergers, by reducing the bureaucracy associated with CMA involvement in merger reviews (9a). It will also encourage collaboration between providers (9b) and to increase the autonomy of the NHS in licensing. The proposals may also have the benefit of removing administrative burden to Trusts of complying with processes that are not designed for or suited to the health system.

**Risks and mitigations**
There is a risk that removing the CMA’s role in assessing mergers will lead to reduced oversight on the rationale for those mergers. For example, there is a small risk that mergers go ahead which are not in the best interest of patients. In addition, there may also be a risk that not having a regulator independent of the health sector will lead to sub-optimal economic outcomes from mergers. It may be that the economic considerations of competition, and the links to wider national competition policy are to some extent lost. However, as previously mentioned, in practice the CMA has only blocked one merger (in 2013), and that this merger was subsequently allowed. It is also unlikely the CMA would block any mergers that were presented correctly, and which focused on demonstrating the patient benefits that would accrue as the result of such a merger\(^\text{38}\). The key mitigation to this is that NHS England and Improvement will continue to review and sign-off mergers, whilst the Secretary of State will now sign off all mergers (not just those including an NHS Trust).

11. **Provider selection and Choice**

**Proposal summary**
This set of proposals makes changes to legislation to enable new regulations to be made which provide decision-making bodies (including Integrated Care Boards, NHS England, NHS trusts, and NHS foundation trusts, local authorities and combined authorities) with flexibility when deciding the circumstances in which competitive tendering should be used to arrange services. If these powers are exercised, the intention is to introduce regulations so that decision-making bodies would be subject to a new provider selection regime when procuring health care services which would encourage them to do so in a way that secured the best outcomes for patients and the taxpayer.

These measures also include proposals to ensure that patient choice is maintained and strengthened where appropriate. This is intended to mitigate any risk to patient choice rights or protections in legislation affected by the set of changes on procurement.

The proposals in this section are to:

a. revoke the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 (PPCCR 2013), and repeal section 75 of the Health and Social Care Act 2012;

b. create an enabling power to remove arrangements between NHS commissioners and providers of healthcare services from the scope of the Public Contracts Regulations 2015 (PCR 2015);

c. create a power that allows for the introduction of a new NHS provider selection regime via regulations – to be informed by public consultation and supported by statutory guidance – which sets out how decision-making bodies should secure the best outcomes for patients and the taxpayer; and

d. introduce legislative changes to preserve and strengthen patient choice; under the new model, bodies that arrange NHS Services will be required to protect, promote and facilitate the right of patients to make choices with respect to services or treatment.

There was a high level of support for reforming the current procurement rules when asked as part of the NHS consultation\(^{39}\). Of the 578 respondents to the question “Do you agree with our proposals to free up procurement rules including revoking section 75 of the Health and Social Care Act 2012 and giving decision-making bodies more freedom to determine when a procurement process is needed, subject to a new best value test?”, 75% of respondents either Agreed or Strongly Agreed. This proposal acts on the preferences of key stakeholders to improve the provider selection arrangements in the NHS.

The impact of these changes would be to streamline and simplify the current rules which involve compliance with two different sets of requirements – the PCR 2015 and the PPCCR 2013). NHS commissioning contracts generally fall under the light-touch regime in the PCRs, meaning that they have greater flexibility in how they are procured. However, the PCRs are associated with a significant and/or perceived risk of legal challenge if certain services are not advertised for tender. This can disincentivise attempts to reconfigure services towards more integrated models, even when benefits to patients and to service delivery can be shown.

A key rationale for intervention is that competitive tendering processes can be costly and in some cases not running a competitive tender would result in the same outcome, but without the added costs of running the tendering exercise. When running or partaking in a competitive tendering process, costs are incurred both by commissioners (in writing specifications and running procurement processes themselves) and by potential providers of care (all of whom spend considerable time working up bids if they decide to compete). These providers of health and care may include non-NHS bodies (including independent, voluntary and Civil Society Organisations), who accounted for 10.8% of NHSEs RDEL spend in 2019/20 (or £14.43bn)\(^{40}\). A 2016 report into NHS commissioning by the Policy Research Unit in Health and Social Care Systems and Commissioning stated:

“All the commissioners [who took part in the research] noted, nevertheless, that a large call on resources was needed in order to carry out a procurement process, and that it was not

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\(^{40}\) Department of Health and Social Care Annual Report and Accounts 2019-20, p220 Department of Health (publishing.service.gov.uk)
possible to undertake many of these exercises, due to the limits on their resources. The process was time consuming and cumbersome.\(^4\)

PRUComm (2016) highlighted several different areas where costs lie in the current system based on interviews with several CCGs and providers. In summary, commissioners and providers found that tendering was very resource intensive\(^2\), which is explored in further detail in the cost section below. The proposals enable new regulations to be made which clarify the discretion decision-making bodies have in deciding on the circumstances in which they should use competitive tendering processes to arrange services. In turn, this may remove the need to undertake procurement exercises where competitive tendering has no added value, and in turn provide cost savings. A full assessment of the EANDCB and the impact on small and micro businesses will be undertaken at secondary legislation stage when the details of the provider selection regime are finalised. The impact of the proposals once implemented will be fully evaluated as part of the post implementation review.

The intention is to develop, informed by the recent consultation, a new provider selection regime which will give decision making bodies more flexibility in choosing how to arrange services, factoring in issues like service sustainability and social value. The scope of the new procurement regime is currently being developed and therefore, the uncertainty over the impacts of a proposal is too great to provide a meaningful Equivalent Annual Net Direct Cost to Business (EANDCB) or SaMBA at this stage.

The scope of the regime which determines what decision-making bodies are impacted by this new regime, as well as what goods and services are affected, has not yet been finalised. This means that the number of providers or the number of contracts which will be affected by the regime also cannot be accurately stated at this stage. Further analysis of the number of providers affected by the finalised provider selection regime, and the potential impacts on those (public and private) providers and businesses (including those which are small and micro) is ongoing and DHSC will publish a full assessment of the EANDCB and SaMBA at secondary legislation stage. Were the enabling powers to be exercised, any secondary legislation would take into account views and needs of small and micro businesses. Any exemption for small or micro businesses from the regulations would be investigated during the development of secondary legislation in conjunction with partners across government.

**Costs**

The proposal summary outlined a rationale for intervention based on the current procurement rules leading to high costs to commissioners and providers. These costs are typically in terms of time and resource of staff, but also opportunity costs as those resources may be better used elsewhere.

A specific unit cost for running or taking part in tendering exercises is difficult to calculate as these costs will differ based on the nature of the procurement. For example, a CCG respondent to PRUComms initial 2016 study on NHS health and care commissioning reported that a smaller competitive tendering process “took 18 months to complete and cost around £250,000 spent on salaries and legal advice”\(^4\). Another CCG who took part in PRUComms subsequent 2017 research reported that a recent long and complex competitive procurement process cost millions of pounds\(^4\). This demonstrates there is a wide range in

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potential costs to commissioners for running competitive tendering processes. For providers, including private businesses, costs of bidding as part of competitive tendering process have also been reported. One Community Healthcare Services provider who took part in PRUComms 2017 research suggested that there is an administrative cost of undertaking bids in terms of assessing whether to bid, constructing bids and contracts, and completing presentations. This can come to tens of thousands of pounds per tender\textsuperscript{45}. This administrative cost may include the time taken to attend and understand the nuances of the market engagement exercises run by commissioners, and staff time in drawing up and submitting bids.

The paragraph above demonstrates the potential costs of competitive tendering to (both NHS and non-NHS) providers and commissioners. These proposals therefore enable DHSC to introduce a new provider selection regime which gives decision-making bodies flexibility on when to undertake competitive tendering processes and in doing so may save on costs associated with competitive tendering. This aims to remove the requirement to tender services where there is no clear benefit is doing so, particularly where there is a single preferred provider when assessed against the success criteria of the regime (which may often be the incumbent provider). This flexibility ought to remove unnecessary bureaucracy and generate savings for providers, including those which are private businesses.

Any costs to NHS and non-NHS providers are likely to materialise once a new provider selection regime is put into place following secondary legislation. The primary legislation itself does not impose any costs, but it does provide powers which give government the ability to create a new provider selection regime, which in turn may impact upon costs to business.

At this point in policy development for the Provider Selection Regime (PSR), DHSC do not envisage significant costs to businesses beyond those driven by the existing public procurement regime. The proposals for the PSR are still under development and the proposals and scenarios outlined here are indicative only and based on proposals which NHS England consulted on from February to April 2021. Ultimately, no new procurement regime will come into place until Parliament has passed the Bill and the relevant regulations have been laid before Parliament.

Current legislation governing the procurement of healthcare services is interpreted as requiring a competitive tendering process to procure most contracts. This applies for the procurement of new contracts and the retendering of contracts. Under the PSR, competitive tendering will become one pathway of three. Another pathway towards procurement for healthcare services will be rolling over a contract where a service continues to be provided successfully and retendering would cause undue disruption to services and integration. The final pathway is to allow contract awards without competitive tendering where a service has changed significantly, or is new, but there is no value in running a competitive tender. This may be because there is not a sufficiently mature market from which to choose providers. Similarly, due to the complexity of the required contract to promote better integration of services there may only be one viable provider in a given locality.

When considering costs for businesses of the proposed PSR against the existing regime it is difficult to estimate the likelihood of additional costs for businesses until the PSR is defined, although DHSC will work to ensure such costs are minimised. In the scenario where there is healthy market competition, which should be tested by decision making bodies, then a competitive tendering process will still be used which would come at the same cost to all competitors as under existing tendering competitions. If there is not a market and

competitive tendering is not used for procurement in under the PSR, then awarding the contract directly to the existing or only viable provider will come at a much-reduced transactional cost for those businesses. This may be most likely represented as administrative or potentially legal costs. We expect this to lead to better allocation of resources without incurring additional costs for businesses. Three illustrative scenarios are provided below.

**Scenario 1 – Competitive Tender**

An ICB wishes to procure diagnostic services (e.g. blood testing) for its local area and there are several potential choices of provider who may deliver this service effectively. The ICB decides to run a competitive tender for this service. The tender is underpinned by the success criteria as given in PSR regulations and guidance to determine the most suitable provider. This means businesses as well as statutory providers could bid for the contract. Bidders incur in costs when preparing their bids as businesses currently do at the moment when participating in competitive tendering run by Clinical Commissioning Groups or NHS Trusts now. Therefore, no additional costs driven by policy change are anticipated for businesses in this scenario.

**Scenario 2 – Single Viable Provider**

An Integrated Care Board (ICB) wishes to procure a service to provide sexual health clinics in a rural locality. Due to the remote nature of the area and a lack of statutory providers, there is only one independent provider whose catchment area extends across the relevant area. The ICB decides to award the contract to this provider. This decision is guided by the criteria set out by the regulations and statutory guidance for the PSR. When considering costs for businesses and decision making bodies, this process would arguably save businesses unnecessary costs which may have occurred due to a competitive tendering process being pursued in order to mitigate legal risk of a claim against the decision making body under the existing regime. Therefore, no additional costs driven by policy change are anticipated for businesses in this scenario.

**Scenario 3 – Contract Rollover**

A Local Authority (LA) manage a contract with an independent provider who works closely with the LA and several small local providers to deliver integrated mental health services. The provider has excellent relationships with all the relevant providers and is considered to be invaluable in integrating services to give service users fluid end to end user journeys which increases the effectiveness of the service in delivering high quality outcomes for patients. The LA assesses that retendering this contract would have a high chance of diminishing the relationships between providers and could lead to disrupted services for service used with adverse outcomes for patient health. As such, in the PSR the Local Authority could allow the contract to continue without retendering. When considering costs for businesses, this process would arguably save businesses unnecessary costs which may have occurred due to a competitive tendering process being pursued in order to mitigate legal risk of a claim against the decision making body under the existing regime. While there is a potential income loss for those businesses who could have won the contract had an open procedure happened, no significant additional costs driven by policy change are anticipated for businesses in this scenario.

We are continuing to develop proposals for the PSR including mechanisms for transparency, scrutiny, and remedy. Further information on the final form of the PSR will be detailed in secondary legislation (regulations) and in statutory guidance as stated in the Health and Care Bill. Draft regulations for the PSR will be consulted on publicly as well as circulated for agreement to the RPC with an accompanying separate impact assessment.
The central requirement of the proposed new regime is that arrangements for the delivery of NHS services must be made in a transparent way, in the best interests of patients, taxpayers and the population. Competitive tendering will allow decision making bodies to test the market when this provides an opportunity to add value for patients, taxpayers, and population without generating adverse impacts (e.g. through service disruption or loss of integration between key providers). This in turn will provide businesses with opportunities to enter the market and work alongside decision making bodies to contribute to these objectives. Depending on the design of the new regime, there may be a risk in some instances that removing requirements could lead to the economically optimal option not being identified, as for example there may be reduced opportunities for market entry by providers (which may also be a cost of lost revenue to that provider). However, to mitigate this risk, it is anticipated that competitive tendering will be used unless there is a limited market for a service or a contract is rolled over to preserve a well-functioning service. Where there is a limited market for a service, decision making bodies will have the flexibility to award contracts without competitive tendering which would (if undertaken) not realistically offer sincere opportunities other than to the single viable provider. Where a contract is rolled over to preserve a well-functioning service and wider integration, this is expected to deliver benefits for patients, taxpayers, and the population above and beyond what can be delivered through fragmented services.

Furthermore, there is a possibility of increased costs stemming from a change in the price of health and care services. If a reduction in competitive tendering leads to the provider sector displaying monopolistic behaviour, the increase in market power could lead to a rise in costs of commissioned services. In line with Better Regulation guidance, a competition assessment will be completed once the details of the provider selection regime are finalised as part of secondary legislation.

It is not anticipated that there will be any additional costs associated with maintaining the current patient choice rights following changes to the procurement rules.

**Benefits**

These proposals remove barriers to integrating care at scale, which may give rise to patient and efficiency benefits, by removing the barriers created by the current framework. The policy position is based on strong support from within the NHS, delivering on a conclusion of the Long Term Plan that the removal of non-value-adding transactional processes for the procurement of services will help the NHS deliver better care and better value. Ultimately, the savings that could be achieved from the changes proposed will depend on how effectively NHS bodies and their partners are able to improve arrangement of their services. As mentioned in the costs section, it is not straightforward to quantify savings generated of these changes in terms of reduced administration costs because the scope of the regime has not yet been finalised.

PRUComm in 2016 reported that in some cases, competition was seen as a too confrontational form of commissioning which risked provider and commissioner relationships. Conversely, a respondent to PRUComms 2016 report stated that “*Competition remained an important lever for commissioning provided it was not enforced top down but left within the local decision making remit.*” These proposals therefore support the intention to introduce an improved provider selection regime by removing the bureaucratic processes currently in place, but also giving the flexibility to use competitive tendering processes where appropriate. This is in order to remove the requirement to undertake competitive tendering which does not generate additional value to patients or the taxpayer. This may reduce costs

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for both decision-making bodies and providers in terms of reduced time and resources completing bids, whilst serving the best interests of patients, taxpayers and the population through more integrated services.

Finally, under the current system, some commissioners have said that in order to minimise the risk of legal challenge, they put contracts out to tender even when this is unnecessary, or, go to disproportionate effort to avoid going to tender. A new provider selection regime which offers flexibility to decision-making bodies may reduce the likelihood of legal challenge and of service disruption caused by the current procurement process. A more bespoke NHS procurement process could also reduce bureaucracy and the costs associated with legal advice.

**Risks and mitigations**

The new provider selection regime will require decision-making bodies to continue to seek value and act in the interests of taxpayers; and will contain appropriate protections to ensure decisions can be justified. This will alleviate the possibility of the new regime creating ambiguity in how decision-making bodies ensure proper use of public money.

DHSC are continuing to work with partners across Government in the development of the PSR and the relevant secondary legislation. This is intended to ensure that the risks and benefits of varying policy options are well understood and that the regime is clear and compatible with wider procurement regimes.

The regime will also enable decision-making bodies to address poor provider performance by reviewing contracts against the success criteria set out in the regime. This will be alongside existing measures for challenging poor performance available through NHS England and NHS Improvement, Care Quality Commission (CQC) inspections and CCG management. The regime will give decision-making bodies scope to take into account poor performance when deciding whether to make new arrangements. The Health and Social Care Committee has expressed a concern that the absence of competitive tendering could lead to the provider sector displaying monopolistic behaviour which is detrimental to health and care services. Qualitative research on NHS commissioning post-2012 describes “Independent providers [in the study] were wary of the turn towards cooperative mechanisms in commissioning services as it would decrease their opportunities for market entry. […] Private for-profit providers continued to be critical of how competition has been applied in the NHS”. Continuing effective contract management will be necessary to minimise this risk.

The proposals do not of themselves affect the balance of type of providers in the health and care system. The new regime will give decision-making bodies more flexibility in choosing how to arrange services, factoring in issues like service sustainability and social value, which will give them the ability to plan and arrange services in ways which helps to keep certain services viable. The new regime will also ensure that decision-making bodies seek innovation and consider the impact of their commissioning decisions on the viability of the market, which will mitigate the risk of smaller providers from the independent sector being denied the opportunity to provide services.

The requirements on decision-making bodies commissioners and providers to provide a choice of services are also not affected by the proposals. Patient choice rights will ultimately

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be protected through this package, and patients will continue to have choice of provider via the existing Any Qualified Provider\textsuperscript{49} certification process.

In order to avoid difficulties in decision-making bodies and providers understanding and adhering to the new regime, the changes will be developed in conjunction with the sector, building on the experience of the current procurement regimes. The proposals should ultimately represent an improvement on the current, overlapping PPCCR and PCR regimes.

A risk is also that the net effect of the proposals on the propensity for legal challenge is unclear. On the one hand, the new provider selection regime is intended to simplify the current processes, which ought to reduce the propensity for legal challenge. On the other hand, removing the role of NHS England in commissioner/provider disputes may increase the likelihood for providers to go straight to judicial review, as there is no internal NHS process. Although in many cases, providers choose to use judicial review to resolve disputes, which may mean that potential increases in the propensity for legal challenges is small.

\textit{International trade}

The UK has always protected its right to choose how we deliver NHS health and care services in trade agreements and we will continue to do so. The procurement of the UK’s public services, including NHS healthcare services, are protected in the trade agreements to which the UK is a party by appropriate exemptions and exclusions to ensure we retain our choice to decide how we deliver these services and the standards suppliers must meet. The UK will continue to ensure that the same rigorous protections are included in future trade agreements.

The provider selection regime is being developed to provide the NHS and local authorities with the tools to deliver better value for patients, taxpayers, and the population. As such, this may cause some divergence between UK rules set out under the PSR and rules under the EU system. Depending on the structure of the new regime, this has the potential to impact international trade and investment, but it is currently not possible to estimate how much given the use of the power is not finalised. In line with Better Regulation Guidance, DHSC are engaging with partners across Government including the Department for International Trade to fully assess any implications for international trade.

\subsection*{12. National Tariff}

\textbf{Proposal summary}

The set of proposals relating to the National Tariff are intended to update the legislative requirements to reflect and support the drive towards greater integration in healthcare; make adjustments that remove barriers to desired pricing approaches; and simplify and streamline the pricing process.

The proposals will:

- Allow national prices to be set as a formula rather than a fixed value;
- Provide a power for national prices to be applied only in specified circumstances;
- Allow adjustments to provisions within the National Tariff to be made within a tariff period, subject to consultation on specific provisions alone;

\textsuperscript{49} See \url{https://webarchive.nationalarchives.gov.uk/20130104211353/http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_125442}
• Remove the power to apply to NHS Improvement to make local modifications to National Tariff prices;
• Allow the National Tariff to include prices for ‘section 7A’ public health services, and;
• Allow for the National Tariff to be renamed as the NHS Payment Scheme

NHS England and NHS Improvement has already been working to implement changes to the approach to tariff; the legislation will give increased flexibility and remove the need for complicated workarounds.

Costs
The National Tariff payment system already allows significant flexibility to support new ways of delivering care. Rules on locally determined prices currently allow providers and commissioners to set appropriate local prices and payment approaches, provided they are in the best interest of patients, promote transparency and result from the engagement of commissioners and providers. These proposals will better enable this.

New and more flexible payment models rely on the capability within the system at a local level to implement and design the payment systems to create the right incentives which support collaboration. This will require support from NHS England and NHS Improvement to ensure that any new pricing approaches are clear and practically deliverable.

Benefits
New pricing and payment approaches that move beyond simple activity-based prices would support moves towards collaboration and integration within the NHS. Replacing the current practice of reliance on local pricing rules for more innovative and flexible pricing and payment approaches and would give the sector greater guidance and certainty.

Moreover, being able to set full pathway prices for care that cuts across different settings and services is an important aspect for the National Tariff to directly influence and enable integrated care.

There is the potential for administrative savings from the introduction of multi-year or multi service contracts between organisations in local areas, and from the reduced administrative burden of responding to multi-year rather than annual tariff consultations. However, it is not clear at present whether there will be a net administrative saving or cost.

Risks and mitigations
There is a risk that the option for part of the National Tariff to be changed mid-tariff could result in an increased uncertainty for commissioners and providers. However, as demonstrated by the departure from the National Tariff at the beginning of the Covid-19 response, flexibilities such as these can be helpful and even necessary for the system.50

Under usual circumstances, this risk will be mitigated by the duties to consult on changes to the National Tariff before they are introduced.

If the rules are unclear or complex this may lead to some additional work for commissioners and providers to identify relevant activity and assign different prices; it may also limit the information available to independent providers. This may have implications for allocative efficiency. Again, existing duties seek to mitigate these risks: NHS England and NHS Improvement will continue to consult on tariff proposals and continue to publish a tariff and financial frameworks in collaboration with DHSC.

13. New trusts

Proposal summary
This proposal clarifies the current legislation which provides that the Secretary of State has power to create new NHS Trusts. New trusts could be created to facilitate integration, as well as to ensure the health system is structured to deliver the best outcomes for whole population health and respond to emerging priorities.

Commissioners may apply to the Secretary of State for the creation of new NHS Trusts. This would, in turn, enable the Secretary of State to establish new trusts to spearhead delivery of the ICBs’ integration goals at place level, through holding and delivering an Integrated Care Provider contract or similar population-based contract, and in a way that aligns with the delivery architecture of their primary care networks.

The Secretary of State powers to create a new trust would not be limited to the circumstances above. The experience of the Covid-19 pandemic, and the creation of the Nightingale hospitals has demonstrated there may be wider circumstances where it would be beneficial for the Secretary of State to be able to create NHS trusts for a variety of purposes. This will require repealing the un-commenced 2012 Act provisions on abolishing NHS trusts.

It is the expectation that the new power will be used rarely when not triggered by a local application. A scenario where the Secretary of State would create a new trust against the will of NHS England or the local systems affected is not anticipated. In any circumstance, local engagement would still be expected before a new trust can be created.

Costs
With respect to commissioner applications, this proposal has no direct cost. It is intended to enable local change, should this be locally desirable. The costs associated with the formation of a new NHS Trust are outside the scope of this impact assessment: it would be for local evaluation by local commissioners in putting together an application to create a new Trust for this purpose, and demonstration of this could be one of the conditions affecting the Secretary of State’s decision whether to approve a request for a new NHS Trust.

For the remaining circumstances, costs depend on decisions to create new trusts that have not been taken, and that are not expected to occur often. In any circumstance, local engagement would still be expected before a new trust can be created.

Benefits
This proposal is primarily intended to help overcome a local implementation challenge. CCGs have found local delivery partners unwilling to use an existing NHS trust or foundation trust as the Integrated Care Provider contract holder.

In some areas, a strong preference has been expressed by delivery partners, to create a new statutory provider, designed specifically for the purposes of providing a whole population health model and with a bespoke structure that contains the breadth of expertise necessary to deliver a broad contract scope. However, the existing legislative framework does not lend itself to the creation of new statutory providers for this purpose.

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51 One of the available options for systems to enable joined up decision making and integration of services. It will enable commissioners to award a single contract to a provider that is responsible for the integrated provision of general practice, wider NHS and potentially local authority services.
Risks and mitigations
This proposal is an enabling power. It will be for local areas to assess the costs, benefits and risks of any proposal to create a new NHS Trust; and this will be tested by NHS England as part of the Integrated Services Assurance Process (ISAP) before a contract is awarded.

There is a risk the power to create new trusts is used more often, or in different circumstances, than anticipated. However, this proposal simply clarifies in legislation a power the Secretary of State clearly had before the 2012 Act was enacted, from which major risks did not materialise. As before, any creation of a new trust will come with an expectation of local engagement, which provides some mitigation.

14. Special Health Authorities Time Limits

Proposal summary
This proposal would remove the existing automatic requirement for Special Health Authorities (SpHAs) created since 2012 to be abolished within three years of being established. The three-year time limit for Special Health Authorities was introduced in the 2012 Act, to apply to new Special Health Authorities from that point forward. A number of Special Health Authorities were already in existence and so their tenure has been enduring. The time limit was intended to maintain a stable system architecture by ensuring that when a Special Health Authority is required for a specific purpose, it does not continue to exist once that purpose has been met. The legislation allows for the three-year limit to be extended via an order subject to the affirmative parliamentary procedure.\(^{52}\)

One of the intended effects of the time-limit was to prevent the proliferation of Special Health Authorities, and the creation of new authorities has indeed been limited - only one, the NHS Counter Fraud Authority, has been created since the change in legislation and the nature of its remit is such that it has enduring purpose. Special Health Authorities are recognised as a critical part of the arm’s-length body landscape and do highly specialised work; this change would place the NHS Counter Fraud Authority on the same footing as the Department’s other Special Health Authorities. To give both strategic and operational clarity, it is important to change legislation to ensure that Special Health Authorities do not have a three-year expiry, and instead use affirmative parliamentary procedure if the Secretary of State for Health and Social Care wishes to dissolve such a body.

Costs
Changing the presumption in law that Special Health Authorities, both new and established after 2012, are a permanent fixture of the health service DHSC, additional costs are not expected, as this was already the established practice.

Benefits
Amendments to legislation will provide continuity of operational delivery, and clarity within the arm’s-length body landscape. They will bring some additional reassurance to Special Health Authorities that they are not in legislation as a temporary fixture, and that they have parity with other arm’s length bodies. However, these changes are occurring within a new context where the Secretary of State will have a new power to transfer functions to and from arm’s-length bodies (section 14) through secondary legislation.

The legal expiry date means that DHSC must apply for an extension for post-2012 Special Health Authorities at least every three years. By removing the need to reapply for an

\(^{52}\) See [https://www.legislation.gov.uk/ukpga/2012/7/notes/division/5/1/8/3](https://www.legislation.gov.uk/ukpga/2012/7/notes/division/5/1/8/3)
extension, there will be a small saving of resource on the part of the Civil Service, lawyers and Parliament.

**Risks and mitigations**
We anticipate limited risks from this policy, it is purely a structural change to bring the one ALB (NHS Counter Fraud Authority) into line with the other Special Health Authorities.

15. **Arm’s-Length Bodies transfer of functions power**

**Proposal summary**
This proposal will create a general power in primary legislation for the Secretary of State for Health and Social Care to transfer functions to and from Arm’s-Length Bodies (ALBs) and to provide for functions of the Secretary of State that could be delegated to a Special Health Authority, instead to be delegated to a non-departmental public body. Consequential upon this, the Secretary of State will have power to abolish a body if all of that body’s functions have been transferred. There will be a specific exception to this for NHS England, providing that the Secretary of State may not render it redundant by a transfer of all of its functions to other bodies. This power will allow the Secretary of State to make changes to primary legislation, by using secondary legislation. However, any changes will require further Parliamentary scrutiny and consultation before coming into force.

The existing ALB landscape has remained largely unchanged since the 2012 Act reforms. As the health service has evolved, this fixed ALB structure has led to a fragmentation of roles between different organisations and has often resulted in mixed messages and competing priorities being disseminated to providers.

The current process for making changes to improve the ALB landscape is currently unsatisfactory in a system where the NHS is ever evolving. This power is designed to provide greater resilience to future system stresses, and to support and foster the flexibility that ALBs have shown in dealing with the pandemic. It will allow the system to adapt and shift to changes in priorities and focus over time, rather than having to introduce complex and bureaucratic workarounds.

The following ALBs will be explicitly out of scope of the power given their particular technical and regulatory functions, and their need to maintain independence of decision making:

- Care Quality Commission (CQC)
- National Institute for Health and Care Excellence (NICE)
- The Health Service Safety Investigations Body (HSSIB)

Executive Agencies, such as the Medicines and Healthcare products Regulatory Agency (MHRA), are legally part of DHSC, meaning that the Secretary of State can already make arrangements for their functions to be carried out by other bodies.

Otherwise, a wide range of Special Health Authorities and Non-Departmental Public Bodies will be within the scope of the power.

**Costs**
There are no direct costs from the introduction of this proposal. However, there may be indirect costs which will depend upon if and how the power is used. For example, if the power is used to transfer functions to or from an ALB, this may incur administrative costs such as those associated with staff transfers, changes to websites and publicity of these changes to stakeholders. Specific costs cannot yet be quantified as it would depend on the
extent of functions being transferred and the organisations involved. This will be considered as part of any transfer of functions and the relevant enabling legislation.

**Benefits**
The ability to transfer functions across ALBs will make it easier for the system to respond to differing challenges such as pandemics or winter pressures more swiftly in future.

This proposal will provide a flexible solution to the question of how to adapt swiftly the ALB landscape to meet emerging challenges facing the NHS. At a time when the NHS is constantly evolving, the current process for amending the functions of ALBs, which requires the passage of primary legislation, is unsatisfactory. By giving the Secretary of State the power to transfer functions through secondary legislation, the proposal would enable the system and the Government to continue to respond to new pressures at speed and continue to deliver on the NHS’s usual objectives. The 2012 Act was based on the idea that there was a range of autonomous bodies with fixed roles in the system holding each other to account within a rules-based system. As the system moves away from that to a more collaborative, flexible approach to delivering the best health and care outcomes for people, the ALB landscape also needs to be flexible and adaptive.

**Risks**
There is a risk that the future use of this power will result in organisational uncertainty for the NHS. While the use of the power by the Secretary of State should be proportionate and executed with the intention that the change will be of overall benefit to the NHS, there is still a risk that this could create an operational distraction.

**Mitigations**
Several mitigations have been incorporated into the policy against these risks. Firstly, the HSSIB, CQC and NICE are excluded from the scope of the power as these are regulatory organisations with roles that depend on remaining independent from other parts of the NHS. As a result, it would be inappropriate for these organisations to have their functions altered without appropriate democratic oversight. Executive Agencies, such as the MHRA, are legally part of DHSC, meaning that the Secretary of State can already make arrangements for their functions to be carried out by other bodies.

Secondly the choice of an affirmative resolution procedure ensures that both Houses of Parliament will have the chance to scrutinise the use of the power; members of these Houses can receive representations from organisations usually consulted on changes to ALBs.

Finally, this power will enable the movement of existing functions to and from ALBs but will not be used to create new functions.

Before any changes are implemented to the ALB landscape using the power, there will need to be a minimum six-to-eight month process involving consultation with relevant ALBs, and devolved administrations where appropriate; due diligence of the terms and conditions of affected staff; pension implications; geographical considerations; decisions around ALB Boards; and consideration of any shared or back-office functions. These processes should prevent undue organisational upheaval.

16. **General power to direct NHS England**
Proposal summary
This proposal will give the Secretary of State for Health and Social Care a power to direct the newly formed NHS England. This will allow the Secretary of State to direct NHS England on its functions, with specific exemptions for functions involving individual clinical decisions, decisions related to the NICE process and appointments. The intention is that this power will strengthen the Secretary of State’s existing powers of intervention over NHS England, as a proportionate measure in response to the concentration of national functions and powers within NHS England as a single organisation. The proposal will be accompanied by the repeal of existing duties to promote autonomy on NHS England and CCGs.

This power is needed in response to the evolution of the system in recent years and the changes that the Bill will bring in to take that evolution further. It is important to emphasise that the power is not a general power over the NHS but, rather, a power to direct NHS England (in its new, merged form) with respect to its functions. The power will sit alongside other powers such as the power to set a mandate for NHS England and the power to appoint the chair of that body. Taken together, these powers (including the new power over NHS England) would give the Secretary of State the ability to address both strategic and more immediate issues in a proportionate, agile and timely manner. This will help to reinforce the connection between NHS decision making and democratic scrutiny and oversight.

Costs
Direct costs arising from this proposal are expected to relate to any new reporting or transparency arrangement; these will depend on the guidance, to be set out, around how the new power can be used but are expected to be small. Indirect costs, arising from specific uses of the new power, cannot yet be quantified.

Benefits
This proposal could have the benefit of reduced bureaucracy as both the Secretary of State and NHS England will be able to more easily express their priorities, and when combined with existing powers over Monitor and the Trust Development Authority, will be able to direct the whole system towards delivery. Clarity of expectations is meant to lead to better outcomes, along with requiring fewer incentives and less performance management to deliver on objectives.

Risks and mitigations
There are simultaneous risks that the Secretary of State will either use the Power of Direction more often than is helpful (and more than is envisaged) providing the system with further administrative burdens; or that it will not be an effective tool in driving change. There is also a risk that the intended benefits of reduced bureaucracy do not materialise, with DHSC and NHS England moving to a more formal, less cooperative way of working.

Government is expected to set out transparency arrangements for use of the power. Any direction made by the Secretary of State must be made in writing, published and be made in the public interest. Ministers are also limited in their use of the new power by the usual public law principles. The public scrutiny of the use of this power should counter any possible reputational and practical risks associated with over, or under, utilising it.

17a. The NHS Mandate (and Better Care Fund)
Proposal summary
DHSC are proposing to amend mandate setting provisions to ensure the mandate will apply to the merged NHS England and NHS Improvement and can be used effectively as a flexible and strategic objective setting tool.

Currently, the Secretary of State is required to publish a mandate to NHS England under Section 13A of the 2006 NHS Act before the start of each financial year. The mandate must specify the objectives that NHS England should seek to achieve in that financial year and subsequent financial years if appropriate, and it must also confirm the capital and revenue resource limits that it should work within. This proposal plans to:

- Amend Section 13A to remove the current duty to publish and lay a mandate annually before the start of the financial year, and instead simply require the Secretary of State to have a mandate in place.
- Given the intention to decouple the mandate from the annual financial cycle, the proposal also removes the duty to include in the mandate the annual limits on capital and revenue resource use, and the power to do so for subsequent years. Instead, it is the plan to attach these to the (currently optional) statutory annual financial directions to NHS England. These directions will be made mandatory and will also need to be published and laid before parliament.
- The Secretary of State currently has powers, linked to the annual mandate, to direct NHS England to use a specified amount of funding to further the integration of health and social care, and meet national conditions set for the funding. Currently, this is delivered through the Better Care Fund. To ensure this important lever for delivering the Fund continues to work effectively, these will be recreated as a separate power.

Costs
As now, decisions on the annual revenue and capital resource limits for NHS England will continue to reflect wider financial decisions on health and care, including through Spending Reviews, the Budget and other negotiations. These decisions will simply be given statutory effect through annual financial directions rather than the mandate document but will be taken into account (as they are now) in developing mandates to ensure that expectations in mandates remain affordable. No additional administrative costs are expected to arise from this measure.

Benefits
The annual deadline for laying and publishing a new mandate has made it increasingly hard for the content of each mandate to reflect the outcome of Government’s wider strategic decisions on health and care that are not aligned to the financial cycle – including in light of Spending Reviews and Budgets that occur late in the financial year. These proposals will better support the Secretary of State in ensuring that the strategic direction that he sets for NHS England through the mandate is fully aligned to broader Government priorities for health and care and is also responsive to changing need.

The requirement for a mandate but not explicitly tied to the annual cycle will provide maximum flexibility on when, and how often a mandate must be set and each mandate will remain in force until such time as it is replaced. Removing the obligation to review and republish priorities for NHS England in a mandate for each new financial year will allow the Secretary of State to set long term objectives and underpinning delivery expectations without the inherent tension that the inevitability of an annual review involved. At the same time, Covid-19 has demonstrated that there will also be times when the NHS needs to transform at much faster pace, and therefore the value of increasing the Secretary of State’s ability to replace a mandate after a shorter interval if necessary to respond to rapidly changing needs. The Secretary of State will have more power to update a mandate after shorter intervals.
where necessary to reflect new strategic commitments, emerging evidence on need, and unforeseen external events that unavoidably impact on the NHS.

**Risks and mitigations**
The main risk associated with this proposal is that delinking the mandate from financial instruments (revenue and capital limits, the Better Care Fund) and the financial annual cycle, leads to a disconnect between Government decision making on the priorities that should be set for the NHS, and the affordability of those priorities. Any mandate set for NHS England by Government will by its nature always need to be reasonable and deliverable with the capital and revenue funding that the Government has allocated for NHS England. However, this risk has been mitigated through the proposed strengthening of statutory annual financial directions to NHS England so that these will be mandatory and will need to be laid in Parliament.

There is also a risk that enabling mandates to be replaced as and when necessary to reflect changing Government priorities could hamper NHS planning and contracting decisions that align with the annual finance cycle. There will continue to be a duty on the Secretary of State to consult NHS England, Healthwatch England and any other persons he considers appropriate before setting a new mandate. Furthermore, a safeguard is being put in place that NHS England will not be required to amend its own business plan if any mandate is replaced within a year of it being laid in Parliament.

**17b. Amendment on Cancer Outcomes in the NHS Mandate**

**Proposal Summary**
This proposal would require the Secretary of State to set objectives in the NHS Mandate on cancer treatment which are defined by outcomes (such as one-year or five-year survival rates), and would give those objectives priority over any other objectives relating to cancer treatment (such as waiting times).

The NHS Long Term Plan (LTP) set a new ambition that, by 2028, the proportion of cancers diagnosed at stages 1 and 2 will rise from around half now to three-quarters of cancer patients with a stageable diagnosis – this is a deliberately challenging ambition. Achieving this will mean that, from 2028, 55,000 more people each year will survive their cancer for at least five years after diagnosis. Priorities include early diagnosis, faster diagnosis, investing in new equipment and workforce, speeding up innovation to business-as-usual, personalised care and follow-up pathways.

**Costs**
This proposal does not directly impact budget provisions for cancer treatment, and no additional financial costs are expected to arise as a result of this proposal. NHS LTP funding covers the existing cancer commitments. However, as noted under Risks, depending on how this is applied, it could give rise to opportunity costs, and potentially allocative inefficiency, if high-benefit non-cancer interventions are displaced.

**Benefits**
The proposal may complement current ambitious cancer stage and survival targets outlined in the NHS LTP (see above). Realising these potential benefits will depend on how the amendment and subsequent NHS Mandate would affect prioritisation of clinical activity. The benefits of this amendment are therefore unclear at this stage.
Risks and mitigations
The proposal, as it stands, may cause unintended consequences due to the prioritisation of objectives for cancer treatment defined by outcomes over other cancer related objectives. There is a degree of ambiguity in how “treatment” should be interpreted, for example whether or not it includes diagnosis or end of life care. Prioritising outcomes may have a negative impact on other LTP commitments. The interventions which contribute to survival go beyond “cancer treatment”, and that is why the LTP adopted an early diagnosis ambition because early diagnosis is a significant driver of survival. The interventions which increase early diagnosis include: raising public awareness of symptoms of cancer; increasing uptake of the three cancer screening programmes; introducing targeted lung health checks; trialling new tests like the Grail Galleri blood test to assess what contribution it can make to earlier diagnosis; and, improving the referral pathway in primary care. It is not clear whether a strict reading of the clause would enable the Secretary of State or by extension the NHS to prioritise these types of intervention over cancer treatment interventions (e.g. new drugs, increased investment in radiotherapy etc).

Prioritising outcomes on survival and treatment may also have an impact on key issues like patient experience, personalised care and living with and beyond cancer. There may also be implications for end of life care and cancers which are already more survivable (e.g. breast cancer, prostate cancer and melanoma). The proposal could also risk being perceived as deprioritising process targets, essentially waiting times, some of which are targets set out in legislation and which are incredibly important for patients and also to incentivise services to streamline pathways.

Introducing an increased priority on cancer outcomes may cause clinicians to carry out some cancer treatments that may result in the delay or cancellation of other activities that would ultimately have resulted in a greater health benefit. It may therefore reduce the overall (cost-) effectiveness of the health service. Interpretation of the amendment may also affect treatment of other services as well as cancer.

As outlined in proposal 17a, the NHS Mandate is meant to be flexible to reflect current Government priorities; any legislation requiring certain objectives be prioritised may hinder the advantages of a flexible NHS Mandate, and efforts to improve outcomes under uncertain future circumstances.

Prioritising outcomes as a result of this proposal may mean using a historic measure to assess performance, rather than a more timely one. This may cause challenges in assessing current performance. For example, a longer term outcome measure, such as the five-year survival rate measure outlined in the NHS LTP, would imply a potential lag of seven-years before we see any impact from the introduction of a policy in the NHS Mandate. If instead performance is based on measures with a shorter lag, such as waiting times, this may reduce challenges in trying to assess current performance. A potential risk of focussing solely on outcomes is, therefore, a delayed ability to respond to changes in performance.

18. Reconfiguration of services: intervention powers

Proposal summary
Hospital and community health services in the NHS are often subject to service reconfigurations – changes in the provision of care – usually as part of a reorganisation of
services across a larger health geography. Reconfigurations, most frequently associated with the location or the type of treatment provided, can occur for a variety of reasons, for example in response to financial or workforce pressures, to provide more clinically effective outcomes, improve patient access to healthcare or react to new medical and technological developments. The scale of possible change is broad, from the small-scale closure of a GP surgery to a more significant replacement of a number of stroke units with a centralised hyper acute stroke unit.

NHS England’s *Planning, assuring and delivering service change for patients* guidance sets out best practice for ‘substantial service change’. This guidance sets out the need for a clear clinical evidence case underpinning reconfigurations, and recommends that for complex service change commissioners should consider Clinical Senate advice. Clinical Senates were instituted in April 2014 and are the primary source of external clinical advice and support for local teams leading a reconfiguration. Clinical Senates conducted 114 clinical reviews (ranging from 14 to 26 per year) in the 2014-2019 period, giving us a partial perspective on the number of complex reconfigurations in England. Between 2007 and 2012, the National Clinical Advisory Team – which for this period provided the clinical support now expected of Clinical Senates – reviewed 124 reconfigurations.

The current system for reconfigurations works well in the main and the intention is to leave it in place for the majority of service changes. There are, however, some reconfigurations that give rise to significant cause for public concern and can lead Ministers to assess that there is a critical benefit or cost to taking a particular course of action. There is currently a lack of formal mechanism that would allow the Secretary of State to intervene – or “call-in” service change proposals – and take a decision on a reconfiguration matter. This is particularly critical now, given the ongoing 40 hospital programme as part of the Health Infrastructure Plan and the development of new ways of delivering care in response to demographic change and as part of the recovery from the pandemic.

The reconfiguration of services intervention power would enable the Secretary of State to call-in service change proposals, and it would not be tied to any particular stage of a reconfiguration process. It would also enable the Secretary of State to act as a decision-maker in relation to service reconfigurations he has called in.

**Costs**

Costs are ultimately dependent on how the Secretary of State chooses to use the new reconfiguration of services intervention power. The number of specific reconfigurations in which the Secretary of State is expected to intervene as a decision-maker is expected to be small. However, if he does intervene and this slows down a reconfiguration there could be increased costs to the NHS and local healthcare systems such as: administrative costs to respond to the Secretary of State queries, cost of contract extensions with builders, delayed realisation of efficiency savings.

In addition, the ability to call-in any reconfiguration could lead to new departmental administrative costs. These include:

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• Costs associated with providing administrative support for the new system and, in particular, to source the clinical advice ministers might need to make effective and defensible decisions; this would complement the expert advice currently available through the Independent Reconfiguration Panel.
• Costs associated with creating effective data flows and information links on service changes. This would be necessary to ensure the Secretary of State has appropriate information across reconfigurations to be able to call them in. This could be a particularly significant cost if cases monitored for call-in extended much beyond the remit of complex reconfigurations Clinical Senates have visibility over (15-25 per year), and if duplication with data flows to other bodies (ICSs, NHS England and NHS Improvement, Local Authorities) could not be avoided.

Benefits
Benefits are ultimately dependent on how the Secretary of State chooses to use the new reconfiguration of services intervention power. The new power would enable the Secretary of State to intervene in challenging reconfigurations earlier, instead of doing so only when NHS Trusts are at risk of failure, or at the request of local authorities and at a very late stage in the process. The main expected benefit would be a reduced number of proposed reconfigurations reaching a deadlock locally. Where the Secretary of State decides a different plan to an original proposal should be followed, it can be reasonably expected that this would be a better outcome for the health and care system as a whole. This could also, in some cases, mean that a successful conclusion was reached more rapidly and thus time and energy that would otherwise have been lost would be available for other purposes within the system.

Risks and mitigations
What constitutes a service change that merits, or not, ministerial attention can be subjective, and might change as reconfiguration proposals develop – it would be primarily a matter of ministerial judgement. The existing local authority-led referral system would likely be replaced by much broader and more active lobbying groups; to ensure equitable reviews, the department would need new administrative processes to provide adequate support to ministers (including clinical expertise) and new data flows allowing adequate scrutiny of complex reconfiguration cases prior to call-in, as described in the Costs section.

The role of service change consultations – involving patients and the public – will be unchanged, and not be subject to ministerial decisions directly.

19. Public Health power of direction

Proposal summary
This proposal confers a power on the Secretary of State to be able to require NHS England and ICSs to exercise any of their public health functions. At present, the Secretary of State can arrange for NHS England, a CCG, local authority or combined authority to exercise any of his public health functions, but this requires an agreement by both parties. Services in scope will include national immunisation programmes, national screening programmes, and public health services for adults and children in secure and detained settings in England.

This proposal will provide an additional mechanism to ensure effective preparations are made by the NHS for medium and long-term challenges, particularly annual winter pressures and the recovery and renewal needed following Covid-19.
Costs
It is expected that the delegation of public health functions will continue working on the basis of agreement in most circumstances. In the rare occasions requiring direction, this would likely change the timeline of agreement rather than the outcome; additional costs, if any, are therefore expected to be very limited.

NHS England is financed for exercising the Secretary of State public health functions as part of its overall mandate funding envelope; this proposal would not of itself change the funding envelope.

Benefits
The delegation of public health functions is expected to continue working on the basis of agreement in most circumstances. In the rare occasions requiring direction, the power provides a decisive way to resolve a real or apparent impediment which could otherwise frustrate the ability of the Secretary of State to discharge functions and duties placed on him in statute in the most effective way, or where directions would be desirable for purposes of timeliness and clarity. The provision of effective preventive services can also help the NHS to reduce costs in the round – for example, widescale provision of flu vaccinations helps to reduce demand on the NHS during winter when it is also likely to be contending with Covid-19 and pressures from reduced elective capacity.

Risks and mitigations
There is a theoretical risk that the power could be used to require additional functions to such a degree that, alongside the other responsibilities placed on NHS England, the organisation would not have the capacity to carry out these functions in the manner requested. While the Power of Direction could compel NHS England to conduct the functions in a certain way, it is highly unlikely that this would happen without appropriate prior discussions and awareness of burdens on capacity and resources.

20. Abolition of Local Education Training Boards

Proposal summary
This proposal removes Local Education Training Boards (LETBs) from statute and allows Health Education England (HEE) flexibility to set its own regional operating model. HEE is the Arm’s Length Body (ALB) responsible for the planning and delivery of education and training for the NHS and public health workforce in England. HEE is supported in its work by a network of LETBs. These are statutory sub-committees of HEE. Their function is to exercise HEE’s functions at local level i.e. responsible for the training and education of NHS staff (both clinical and non-clinical) at a local level. However, this can be achieved through HEE regional staff accountable to the HEE Board working with local NHS Bodies on an individual basis or appropriately overseen at a place-based level.

LETBs have become outdated and it is important that HEE have the flexibility in establishing its regional operating model to allow greater joint working with the (non-statutory) Regional People Boards and ICS. LETB functions will continue to be undertaken by HEE staff reporting to the HEE Board.

LETBs were established to; develop and deliver local education and training plans; and to allocate HEE resources to deliver the right workforce for the constituent population. This work largely consisted of the commissioning of undergraduate clinical places and overseeing
the delivery of commensurate contracts with Higher Education Institutes (‘HEIs’) to deliver the places available. Reforms to healthcare education funding started to take effect from 1 August 2017, with most non-medical healthcare students moving from a bursary-based funding model to loans-based. The cap on student places operated by HEE and its LETBs was removed and has enabled HEIs to expand places and allowed a market-based system to thrive. Therefore, the role of the LETB in overseeing the delivery of the commissioning of pre-registration healthcare courses has significantly diminished as a result. The LETBs also oversee the local allocation of workforce development funding.

If LETBs were not abolished, the statutory HEE functions within their remit would be considered within the non-statutory Regional People Boards, which consider workforce matters in a holistic manner. HEE Staff and/or the LETB Chair would represent HEE on the Regional People Board.

This would create duplication of effort and consequent waste of public money as the LETBs would need to meet separately from the Regional People Board to formally make the decisions on the HEE functions.

When operationalising this proposal, LETBs would continue until the Commencement Order abolished them. HEE would wind down the formal LETB structures with the work reverting to HEE.

Costs
It is not anticipated that there will be any direct costs associated with abolishing LETBs. LETBs are not employers, and the staff supporting LETBs are employees of HEE and will continue to perform HEE’s regional duties. The work of LETBs will continue to be undertaken but by HEE directly. This therefore constitutes a transfer of responsibility rather than a transfer of costs. It is not expected that there will be significant business disruption stemming from this change.

Benefits
There are small savings for HEE generated as the Chairs of LETBs will not receive a payment. LETB chairs are appointed on an annual basis by the HEE Chair and are paid by HEE the same rate as a HEE Non-Executive Director (£7,883 pa). There are currently seven LETBs matching NHS England and NHS Improvement’s regional footprint. The saving would therefore be £55,181 pa, notwithstanding any overheads which are expected to be small.

The main benefit of abolishing LETBs is a reduction in bureaucracy which will make operational decision on workforce activities making more holistic at regional level. The proposal was put forward by HEE to allow them flexibility in their regional operating model.

Risks and mitigations
It might be argued that this proposal takes away clarity of accountability from statute. However, as part of the workforce accountability proposals, a duty is placed on the Secretary of State to publish a report every 5 years describing the workforce planning and supply system which will provide that greater transparency.

21. Workforce Accountability
Proposal summary
This proposal places a duty on the Secretary of State to publish, once every 5 years, a report setting out how responsibility for the workforce planning functions of the NHS are being taken forward.

This report will describe the workforce planning and supply system, including, the roles of DHSC, ALBs, NHS bodies and others, and how they work together in practice. The report would assist stakeholders as it would provide them with clarity and transparency as to how the workforce system operates. The bodies with workforce planning responsibilities set out in the report (HEE, NHS England, ICS) would be held to account through their normal accountability mechanisms of objective setting and review. Additionally, the Secretary of State could be challenged if he failed to publish the report.

NHS England’s 2019 engagement process around their recommendations for legislative reform raised some issues around the respective responsibilities of national organisations in relation to workforce functions. As part of a wider petition organised by the Royal College of Nursing, the following points were made: “Expanding powers for the Secretary of State for Health and Social Care provides a clear opportunity to articulate the new duties for workforce that we have called to be included in this legislation”. A number of other respondents to NHS England’s consultation felt there should be greater clarity on which organisations are specifically responsible for ensuring adequate levels of funding for NHS staffing, including UNISON, and also the Royal College of Physicians. In responding to the Royal College of Nursing (RCN), UNISON, and other royal colleges, NHS England recommended that the Government should now revisit with partners whether national responsibilities and duties in relation to workforce planning were sufficiently clear.

The Department of Health and Social Care agreed that, under the current system, there is scope to improve transparency in the operation of the workforce planning and supply. In response to this, the Bill proposes to make the publication of the workforce report a statutory requirement. However, the Bill will not set out ALB responsibilities in primary legislation in more granular fashion than currently. Our view is that workforce planning is covered within the existing legislation, and to set out specific workforce planning functions for individual ALBs would create an inflexible approach and go against the wider principle of not being too prescriptive in the Bill, recognising that system architecture evolves and sometimes the legislation has not quite caught up. Furthermore, HEE and NHS England are accountable to the Secretary of State for carrying out their functions through the process of objective setting and review, which are legal functions of the Secretary of State.

Committing to publish this report supports the Bill’s key principle of ensuring public confidence and accountability by ensuring that the right framework is in place for oversight of our health system, that national bodies are streamlined with clear roles and responsibilities, and that the public and Parliament can hold decision makers to account.

The Department of Health and Social Care has also considered and rejected:
- A duty for the Secretary of State to be responsible workforce planning, which may be delegated to ALBs.
- A duty for the Secretary of State to be responsible workforce planning, which may be delegated to ALBs with their workforce planning roles set out in primary legislation.
• The introduction of safe staffing legislation akin to the Nurse Staffing Levels (Wales) Act 2016 and Health and Care (Staffing) (Scotland) Act 2019.

 Costs
 There are potential costs associated with resourcing servants to draft the report, although these are expected to be small and have not been quantified.

 Benefits
 The benefit of this proposal is greater transparency and accountability for workforce planning and supply. These benefits would be accrued by external stakeholders (e.g. the RCN) who would be able to use the information provided to hold the system and the Secretary of State to account for ensuring an effective system of workforce planning was in place. Stakeholders would be able to identify where workforce planning was not happening as envisaged by the report and raise it with the Secretary of State or the bodies identified. The benefits of greater transparency and accountability will more generally be felt by providers, patients and the taxpayer.

 Risks and mitigations
 A potential risk is that the proposal does not create greater transparency over the workforce planning system as the report is a description of the current state of play, rather than a prescriptive set of actions. However, it is hoped that this will be mitigated by the report providing clarity on the current situation and the areas in which improvements can be made.

 22. Designating Integrated Care Boards as Operators of Essential Services under NIS Regulation

 Proposal summary
 Integrated Care Boards (ICBs) will be established as statutory bodies via the Health and Care Bill. Assurance is needed to ensure ICBs comply with the required standards in order to reduce cyber risk.

 This amendment designates ICBs as Operators of Essential Services (OES) under the Network & Information Systems Regulations 2018 (the NIS Regulations). This would bring ICBs into an established regulatory framework for cyber security alongside NHS Trusts and large independent healthcare providers, and mean that ICBs must fulfil the security duties under the NIS Regulations.

 The NIS Regulations came into force in May 2018. They provide for legal measures aimed at boosting the overall level of security (both cyber and physical resilience) of network and information systems for the provision of essential services and digital services in those sectors which are vital for our economy and society (such as healthcare, transport and the supply of electricity and water).

 The Regulations require organisations identified as ‘operators of essential services’ (OES) to fulfil security duties to:

• take appropriate and proportionate measures to manage risks posed to the security of the network and information systems on which their essential services rely;
• take appropriate and proportionate measures to prevent and minimise the impact of incidents affecting the security of the network and information systems used for the provision of essential services; and
• report incidents that have a significant impact on continuity of essential services.
The NIS Regulations are overseen by ‘competent authorities’ which fulfil a similar role to a regulator, with the duty to issue guidance and the power to inspect organisations and take enforcement action (including imposing penalties of up to £17 million) where necessary. The Secretary of State for Health is the Competent Authority for the Health Sector.

In England, healthcare services are an essential service for the purposes of the NIS Regulations. Currently, NHS Trusts and Foundation Trusts, along with 28 large independent healthcare providers are designated as OES or ‘operators of essential (healthcare) services’ for the healthcare settings sector in England for the purposes of the NIS Regulations.

DHSC will publish updated guidance on the NIS Regulations that will inform OES (including ICBs) of their responsibilities under the NIS Regulations, and the powers that the Secretary of State through DHSC has as Competent Authority. ICBs would be required to complete an annual Data and Security Protection Toolkit (DSPT) assessment which will be used to assess their cyber security posture. Once ICBs are designated as OES, they will be required to report any incident that affects their network and information systems (providing the incident meets certain impact thresholds, which are also published in guidance via the DSPT).

DHSC expect local ICBs to be taking local level decisions on IT investment (including around cyber security) across their regions, as well as owning systems and the associated cyber risk for systems that are critical to the provision of healthcare. This includes taking some responsibility for the provision of GP IT services from Commissioning Support Units (CSUs). They will also hold the Shared Care Record, and the associated cyber risk, the loss or corruption of data from which could have clear implications for delivery of care, as well as wider public trust in the digitisation and data sharing agenda. Accordingly ICBs should be subject to a robust and focused regulatory framework for the management of cyber risk.

The NIS Regulations provide such a framework and are designed to raise security standards.

There are two principle drivers behind the need to close this regulatory gap:

1. Some of the critical systems that ICBs will own, along with the associated cyber risk, are already in development by the Integrated Care Systems that have been established, and will expand rapidly in both scale and criticality over the next year.

Shared Care Records (ShCR) - which aim to create care records that can be shared between health and care providers - are one such system. Almost all of the 42 ICS already have a basic ShCR in place with the remainder to complete within the next few months. Across the country hundreds of organisations are now connecting into shared care records. Those connections will continue to grow over the coming months and years as will the functionality and scope of the existing shared care records.

NHSX will shortly be publishing ShCR standards to ensure the developing systems are secure by design, but this must be combined with an effective compliance mechanism, and the appropriate regulatory levers to allow Government to step in to gain assurance that critical systems are being adequately protected. While standards will be largely focused on the suppliers of ShCR solutions to ensure the security of design and operation, we need powers to assure the ICBs as data and risk owners. Until amendments are made to the NIS Regulations via primary legislation to ensure that ICBs are covered by NIS, DHSC will have limited
enforcement and compliance measures governing the cyber security of these new patient data sharing arrangements.

2. Regulatory oversight drives compliance with cyber security standards and ensures that vulnerabilities are remediated quicker. Since 2019, DHSC has used its power to issue NIS Information Notices to NHS Trusts (who are designated as OES under the NIS regulations) that require them to address critical cyber vulnerabilities on their networks. Such cyber vulnerabilities are identified in network and information systems regularly and affect all sectors - they are generally fixed by applying patches. Where particularly important vulnerabilities are identified, High Severity Alerts are issued to Trusts, requiring that they acknowledge the alert within 48 hours and remediate the problem within 14 days. The use of NIS Information Notices, combined with communicating the further NIS enforcement action that we could take in the event of non-compliance, has driven compliance with High Severity Alerts and led to the swifter remediation of vulnerabilities. The vast majority of Trusts now acknowledge the alert within the 48 hour deadline (compared to around half in 2019), and either mitigate the vulnerability, or provide an adequate mitigation plan by the 14 day deadline. Without NIS powers over ICBs, DHSC will have limited power to gain assurance that critical vulnerabilities are being adequately addressed, possibly leading to vulnerabilities sitting on their networks for several months, which could lead to a disruption in the provision of care, or a security breach in relation to the shared care record, both of which could realistically lead to patient harm. With 7 High Severity Alerts in 2020, and 8 so far in 2021, this issue alone poses a significant risk.

For context, it is worth noting that one major factor that caused Trusts to be affected by the WannaCry cyber attack in 2017 was failure to implement vulnerability updates recommended by NHS Digital. Legacy systems across the NHS were also a key factor (i.e. systems no longer supported by the manufacturer with security patches). DHSC are currently using our NIS powers as a key part of a programme to reduce the number of unsupported Windows devices in NHS Organisations. Given the critical role that ICBs will play in the healthcare system, it is important that this same regulatory drive for improvement should apply to them also.

In summary, without designating ICBs as OES, there would be a significant gap in the regulatory framework. Although individual organisations are responsible for their own cyber security (and ICBs will be responsible for the cyber security of any IT provision that they provide), as system stewards we have a duty to assure that organisations are taking their responsibility seriously, as well as managing the cyber risks to the wider health care system should there be a large scale cyber attack or an incident with wider ranging impacts.

In putting forward this policy we have consulted with the Department for Digital, Culture, Media and Sport (DCMS) and ensured that this policy expansion is in line with future legislative proposals.

Costs
This amendment will come at no cost to private businesses. The only possible cost impact will be on ICBs, which are the only organisations affected by this amendment. However, NIS compliance in the health and social care sector has been built into existing compliance mechanisms, in an attempt to reduce the burden on OES. The main compliance tool is an annual self-assessment, the Data Security and Protection Toolkit (DSPT). All bodies that process the personal confidential data of citizens who access health services are already
required to complete this self-assessment, so this requirement would be placed on ICBs regardless of whether they are designated as OES under the NIS Regulations.

The NIS Regulations stipulate that OES must take appropriate and proportionate measures to fulfil their security duties of the Regulations (see proposal summary above). However, they do not mandate the purchase of specific IT systems. It is our view that the kind of ‘appropriate and proportionate measures’ that will be required of ICBs are reasonable expectations for any organisation that provides an essential public service (including adequate backups, timely patching of vulnerabilities, appropriate life cycle management of software etc.) However, the NIS Regulations give us the ability to take action where these reasonable expectations are not being met.

DCMS has overall responsibility for the NIS Regulations and has published a post-implementation review57 in May 2020 with the following cost estimates. These figures are cross-sector estimates for all OES (health, transport, water, energy etc.). There will be some variance based on size and scale of the OES in question, amount of operational technology for some OES in addition to standard IT etc. but we can expect ICBs to fit somewhere in these estimates:

- The one off cost of familiarisation per organisation is estimated to be £655.36 per organisation (comprising the salary costs of legal and senior management time).
- The cost of incident reporting is estimated to be £54 per incident. There are already requirements for organisations to report incidents to NHS Digital, so this cost is not new.
- DCMS estimate additional compliance costs of reporting requirements to Competent Authorities - such as completing the Cyber Assessment Framework or another type of assessment - as £80 for a small organisation, £275 for a medium sized organisation, and £549 for a large organisation. ICBs will already be required to complete the DSPT self assessment, so this cost is not new.
- The post-implementation review also attempted to estimate the costs of additional security spending that would be incurred by organisations due to the introduction of the Regulations. Spending was divided into three categories: internal staff costs; physical security; and external costs, with additional spending envisaged on measures such as increasing staffing, investing in IT software, additional risk assessments and audits, staff training and testing and monitoring systems.
- It is worth noting that these are cross-sector estimates - some OES are FTSE 100 companies. Any additional security spending by individual organisations will vary by the existing measures and technical controls they have in place, and the extent to which they judge additional spending to be appropriate to comply with the requirements of the NIS Regulations. As ICBs will be classed as OES under the NIS Regulations from the point of their statutory establishment or soon thereafter, they can take this into account when procuring and building network and information systems, and should not need to retrospectively consider and procure security measures. The cost of ensuring that network and information systems are secure is to a large extent a normal cost of business.
- With the above context in mind, the table below shows estimates for how much an OES could spend on putting additional security measures in place as a result of being designated as an OES under the NIS Regulations. These are taken from the aforementioned DCMS post-implementation review and the DCMS impact

assessment that fed into it. These figures are based on survey responses to the question of spend in the past 12 months, or estimated spend in the next 12 months. The question divided spending into three categories: internal staff costs; physical security; and external costs, with physical security assumed to be a one-off cost and internal and external costs assumed to be annual. If we are to assume that as commissioning bodies, ICBs will have balance sheets that put them into the category of large OES, then an estimate of cost to the system could be calculated by multiplying the low and high estimated costs by the number of ICBs, giving a figure of £4.2 - £8.4 million. However, for the reasons set out above, this figure is perhaps not reflective of the unique position of ICBs among other OES, and we would expect many of the costs of security spending to comply with NIS to be absorbed into the normal spending on cyber security that would be expected from an organisation looking to protect its systems and comply with existing regulations (such as GDPR, DSPT etc.)

Estimates for how much an OES could spend on putting additional security measures in place as a result of being designated as an OES under the NIS Regulations (12 month period)

<table>
<thead>
<tr>
<th></th>
<th>Small OES (not more than 50 employees, turnover &lt;£10.2m, balance sheet total &lt;£5.1m)</th>
<th>Medium OES (not more than 250 employees, turnover &lt;£36m, balance sheet total &lt;£18m)</th>
<th>Large OES (more than 250 employees, turnover &gt;£36m net, balance sheet total &gt;£18m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>High estimated additional costs per business</td>
<td>£1,400</td>
<td>£75,000</td>
<td>£200,000</td>
</tr>
<tr>
<td>Low estimated additional costs per business</td>
<td>£500</td>
<td>£50,000</td>
<td>£100,000</td>
</tr>
</tbody>
</table>

Benefits
Designating ICBs as operators of essential services means that ICBs are subject to the NIS Regulations. This puts in place the requirements outlined above which will improve the security of the network and information systems which ICBs control. As the Competent Authority, this also allows DHSC cyber-specific powers of inspection where there are serious suspected failings, a legal mechanism to require information, for example, about the cyber security of their networks, or to take enforcement action, for example, to require improvements where weaknesses are discovered that could result in a severe interruption to essential services.

Risks and mitigations
By using the Health and Care Bill to make a consequential amendment to the NIS Regulations, we will be bringing ICBs into an established regulatory framework that has been functioning effectively for the past three years. For this reason we see the risks of this proposal as minimal.

Background
In 2014 the NIHR DHSC Policy Research Programme funded four projects under the Health Reform Evaluation Programme exploring different aspects of the new health and social care system following the Health and Social Care Act 2012. The four projects explored:

- The new NHS commissioning system
  (led by Professor Kath Checkland, University of Manchester)
- Diversity of healthcare provision
  (led by Professor Rod Sheaff, University of Plymouth)
- The establishment and operation of Health and Wellbeing Boards
  (led by Professor David Hunter, Newcastle University)
- Commissioning public health services
  (led by Ms Linda Marks, University of Durham)

Research Outputs


