

5 Payment reform

Change the payment system to reflect the move towards integration and collaboration across NHS providers within a place, from general practice to community services and acute care. This would include replacing the default to payment by results (PbR) with a mandate for commissioners and providers to mutually agree a contract form with no default. If they can't agree a contract, then there is no default position should be the expectation, but if necessary could, by exception, be reaching agreements.

- making the provider support fund (PSF) and CCG uplift conditional on reaching agreements
- increasing in arbitration times to both parties to avoid this becoming default and to ensure there is a compelling incentive to reach agreement
- awarding new funding from the long-term plan based on system being able to reach agreement.

4 Procurement, competition and choice

Strengthen elements within Section 75 of the Act so that if the commissioner cannot secure the changes needed within the place and system.

Change the rules around competition and choice so that changes needed, and this includes procurement for general community services.

Relook at how patient choice operates by giving respect and the circumstances within which patient choice should be made judgements with regard to competition between NHS organisations, and the powers of Monitor, the NHS Improvement, in relation to commissioners.

Remove the powers of the Competition and Markets Commission, and the powers of Monitor, the NHS Improvement, in relation to commissioners.

Unlocking integration

Five key asks to enable and support integration across system and place

The transformation of the NHS in England to a more integrated system of health and care is well underway in many parts of the country. The long-term plan for the NHS is expected to continue promoting integration. NHS England chief executive Simon Stevens said that care redesign is already bearing fruit for the 12.5 million people covered by integrated care systems.

"This is where the health and care sector is headed. There is no plan B."

Simon Stevens

There is enthusiasm to accelerate progress as these systems start to deliver better health outcomes for their populations: aiming to be less fragmented, more person-centred, and better at meeting the needs of an ageing population with long-term conditions.

Why are changes needed?

The current architecture of the NHS, as defined in the Health and Social Care Act of 2012, has shortcomings that may not facilitate the changing landscape. Organisational boundaries and accountabilities must evolve. The way in which services are planned and commissioned is changing as commissioners take a more strategic and place-based approach and there

is increasing collaboration between providers, commissioners and local authorities to deliver integrated care with a focus on population health.

While a wholesale rewrite of the Act is neither likely nor welcome, as it would only serve to distract from the task ahead, clinical commissioners have identified five areas where a revised approach will accelerate integration.

How can we make the changes?

Achieving these may require legislative change or they may require the use of current legislation in a different way, including bold approaches to test the flexibility of the 2012 Act. For example, clarify from national bodies about acceptable actions on payment reform, procurement, governance or regulation, or NHS England powers of direction for clinical commissioning groups (CCGs) and NHS Improvement powers of licensing for foundation trusts. Any of these approaches must support bottom up aspirations around sustainability and transformation partnerships (STPs), integrated care system (ICS) place and system integrated working.

1 Responsibility to improve health and health outcomes
Reverses the section the places responsibilities of different parts of the NHS. This should legislate that NHS providers as well as commissioners have responsibility for improving health and health outcomes across a place and system (ICS and/or STP) as well as to their own organisation within that place and system. In addition, mandate other stakeholders, such as public health England and prevention services in a more public health manner within local systems.

2 Accountability and governance

Clarify accountability and governance for commissioners and providers to ensure they are accountable to consult and the NHS. This includes the need to: ensure the place and system is able to deliver the best possible outcomes for the population; ensure the place and system is able to deliver the best possible outcomes for the population; ensure the place and system is able to deliver the best possible outcomes for the population.

NHS Clinical Commissioners
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