

# Proposed modification of the NHS provider licence standard conditions: Condition G4 (fit and proper persons)

## Consultation notice

22 February 2021

# About this document

1. This statutory consultation notice published by Monitor under section 100 of the Health and Social Care Act 2012 (the 2012 Act) gives notice of a proposed modification to the standard conditions of the NHS provider licence. It should be read in conjunction with the annexes which are supporting documents.
2. Monitor and the NHS Trust Development Authority operate as an integrated organisation known as NHS Improvement. In this document references to 'NHS Improvement' should be read as references to Monitor and/or the Trust Development Authority as appropriate to the context. References to 'directors', even where expressly stated, include all those performing equivalent or similar functions.

## Background

3. Providers of healthcare services for the NHS must ensure that their directors (or directors and governors in the case of NHS foundation trusts) satisfy specified requirements. In particular, directors must meet the fit and proper person test set out in regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the FPP Regulations). A copy of regulation 5 of the FPP Regulations can be found at Annex B.
4. NHS foundation trusts and most independent providers of health care services for the NHS must be licensed by Monitor. NHS trusts are not required to hold a licence but are bound by most of the standard conditions of the provider licence, including condition G4. Condition G4 makes provision about fit and proper persons, and therefore applies to NHS foundation trusts, NHS trusts and all licensed independent providers of health services for the NHS.
5. The proposed amendments to condition G4 would provide for consistency with the FPP Regulations.

# Proposed modification to condition G4

6. NHS Improvement proposes modifying standard condition G4 of the provider licence: Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions). A copy of condition G4 in its current form can be found at Annex A. Our proposal is largely a technical amendment designed to align condition G4 with the fit and proper persons requirements set out in the FPP Regulations.

## Reason for the proposed modification

7. Licence condition G4 applies to all providers holding an NHS provider licence and, by way of directions, also applies to NHS trusts. It requires that providers ensure that their directors and governors meet appropriate standards of personal behaviours and technical competence. The objective is to prevent an unfit person from holding office as a director or governor.
8. Since publication of the NHS provider licence, regulation 5 of the FPP Regulations has come into force. Regulation 5 sets out a fit and proper person's test (the FPP test) which applies to directors of all NHS providers registered with the Care Quality Commission, which includes all licence holders and other organisations to which licence conditions apply.
9. To ensure consistency of approach with the FPP Regulations, we propose making some technical amendments to condition G4.
10. Although the FPP Regulations do not apply to governors of NHS foundation trusts, we also propose updating the provisions of condition G4 relating to governors to reflect current practices.

## Effect of the proposed modification

### Provisions relating to directors

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11. While the proposed modification (as it applies to directors) is a technical amendment, it would have the effect of extending the scope of the fit and proper person test as set out in the licence to include:
  - a. qualifications, competence, skills, experience and ability to properly perform the functions of a director
  - b. issues of serious misconduct or mismanagement and
  - c. disbarment in relation to safeguarding vulnerable groups and disqualification from office.
12. In practice, licence holders are already required to comply with these requirements under the FPP Regulations. The effect of the modification is therefore simply to ensure consistency of approach in the provider licence.
13. The modification also removes the requirement for licence holders to ensure that there are contractual arrangements in place for dealing with directors who are unfit. These provisions are no longer necessary since the introduction of the FPP Regulations prohibits licence holders from appointing, or having in office, an unfit director.
14. The effect of the modification is also to remove provisions which have become redundant and brings provisions in line with current working practices, details of which are set out in paragraphs 15 to 18 below.

### Provisions relating to governors

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15. The FPP Regulations do not apply to governors of NHS foundation trusts. The effect of the proposed modification (as it applies to governors) would be limited to bringing the provisions in line with current working practices, as set out in paragraphs 16 to 18 below, and to make minor changes to the wording to provide greater clarity.

### Provisions relating to directors and governors

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16. The proposed modification would remove two provisions which are either redundant or have limited application.

17. The first of these provisions is the reference to Monitor’s discretion to authorise any general exception to the fit and proper person requirements for NHS foundation trust directors and governors. This power has limited application because it applies only to fit and proper person requirements that an NHS foundation trust has included in its constitution and which go beyond the legislative requirements. In practice the power has never been used so the modification would simply remove a provision that is already effectively redundant.
18. The second is the prohibition on holding office as a director or governor for any person disqualified from holding office as a director under the Company Directors’ Disqualification Act 1986. As this provision expressly relates to directors’ fitness and goes beyond the legislative framework for governors, it is proposed that it is removed in relation to governors. For directors, the provision can be removed as it is already covered by the FPP test under the FPP Regulations, which would be incorporated into the licence by the proposed modifications.

## Form of the proposed modification to licence condition G4

19. The proposed modification to condition G4 is in the form set out below:

### **PROVIDER LICENCE**

#### **Licence Condition G4**

#### **Condition G4 – Fit and proper persons as Governors and Directors (also applicable to those performing the functions of, or functions equivalent or similar to the functions of, a director)**

1. The Licensee must ensure that a person may not become or continue as a Governor of the Licensee if that person is:
  - (a) a person who has been made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;
  - (b) a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);

- (c) a person who has made a composition or arrangement with, or granted a trust deed for, that person's creditors and has not been discharged in respect of it;
  - (d) a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on that person.
2. The Licensee must not appoint or have in place a person as a Director of the Licensee who is not fit and proper.
3. For the purposes of paragraph 2, a person is not fit and proper if that person is:
- (a) an individual who does not satisfy all the requirements as set out in paragraph (3) and referenced in paragraph (4) of regulation 5 (fit and proper persons: directors) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (S.I. 2014/2936); or
  - (b) an organisation which is a body corporate, or a body corporate with a parent body corporate:
    - i. where one or more of the Directors of the body corporate or of its parent body corporate is an individual who does not meet the requirements referred to in sub-paragraph (a);
    - ii. in relation to which a voluntary arrangement is proposed, or has effect, under section 1 of the Insolvency Act 1986;
    - iii. which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act) appointed for the whole or any material part of its assets or undertaking;
    - iv. which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act;
    - v. which passes any resolution for winding up;
    - vi. which becomes subject to an order of a Court for winding up; or
    - vii. the estate of which has been sequestrated under Part 1 of the Bankruptcy (Scotland) Act 1985.
4. In assessing whether a person satisfies the requirements referred to in paragraph 3(a), the Licensee must take into account any guidance published by the Care Quality Commission.

# The consultation process

## Statutory consultation and objection process

20. Any proposals to modify the standard conditions of the NHS provider licence are subject to a statutory consultation process under the 2012 Act. This provides an opportunity for licence holders to express their views on, and to object to, the proposals. Further information on the statutory consultation and objection process can be found in Annex C.
21. The 2012 Act sets out the statutory process for challenging a proposed modification to the NHS provider licence. If licence holders object to the proposal, and the number of objections reaches a certain threshold, NHS Improvement may not progress with the proposed modification without a reference to the Competition and Markets Authority or further statutory consultation.

## Who can object to the proposed modifications?

22. While responses from stakeholders other than licence holders will inform any decision about the proposed modification, only objections from licence holders will count towards the objection threshold.

## Impact assessment

23. Under section 69 of the 2012 Act, Monitor is required to carry out an impact assessment where proposals are likely to involve a major change in the standard conditions of the NHS provider licence. This proposal involves only minor and technical changes to the NHS provider licence which are necessary to bring the licence into line with existing legislative requirements. On that basis, an impact assessment is not required.
24. We have carried out an assessment of the equality and health inequalities impact of these proposals and have not identified any issues. We would welcome comments from consultees.

## Consultation questions

1. Do you object to the proposed technical amendment to modify condition G4 of the NHS provider licence? *\*All consultation responses will be taken into account but only objections from licence holders will count towards the objection threshold*
2. If so, what are your reasons?
3. Are there any equality issues that arise (positive or negative) in relation to this proposal? In particular, would this proposal have an impact on any groups of persons sharing a protected characteristic, as set out in the Equality Act 2010?
4. If yes, please outline any potential issues.

## Responding to the consultation

25. If you wish to respond to this consultation, please do so by **midnight on Monday 29 March 2021**. You may submit your response via our online survey: <https://www.engage.england.nhs.uk/survey/proposed-modification-of-the-nhs-provider-licence>, or by email to [nhsi.g4responses@nhs.net](mailto:nhsi.g4responses@nhs.net). The address for postal responses can be found at the end of this document.
26. If you are responding to this consultation on behalf of an organisation, please confirm that you are authorised to do so.
27. Please email [nhsi.g4responses@nhs.net](mailto:nhsi.g4responses@nhs.net) if you have any questions or any difficulty accessing the survey. Please let us know (by emailing [nhsi.g4responses@nhs.net](mailto:nhsi.g4responses@nhs.net)) if all or part of your response or identity is confidential so that we can exclude this from any published summary of responses. We will do our best to meet all requests for confidentiality but, because NHS Improvement is a public body subject to the Freedom of Information Act, we cannot guarantee that we will not be obliged to release your response (potentially including your identity) or part of it even if you say it is confidential.



# Annex A: NHS Provider Licence General Condition G4: Fit and Proper Persons as Governors and Directors

## The Provider Licence

### Condition G4: Current form

#### **Condition G4 – Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions)**

1. The Licensee shall ensure that no person who is an unfit person may become or continue as a Governor, except with the approval in writing of Monitor.
2. The Licensee shall not appoint as a Director any person who is an unfit person, except with the approval in writing of Monitor.
3. The Licensee shall ensure that its contracts of service with its Directors contain a provision permitting summary termination in the event of a Director being or becoming an unfit person. The Licensee shall ensure that it enforces that provision promptly upon discovering any Director to be an unfit person, except with the approval in writing of Monitor.
4. If Monitor has given approval in relation to any person in accordance with paragraph 1, 2, or 3 of this condition the Licensee shall notify Monitor promptly in writing of any material change in the role required of or performed by that person.
5. In this Condition an unfit person is:
  - (a) an individual;
    - (i) who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged; or
    - (ii) who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it; or

- (iii) who within the preceding five years has been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him; or
- (iv) who is subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986; or

(b) a body corporate, or a body corporate with a parent body corporate

- (i) where one or more of the Directors of the body corporate or of its parent body corporate is an unfit person under the provisions of subparagraph (a) of this paragraph, or
- (ii) in relation to which a voluntary arrangement is proposed under section 1 of the Insolvency Act 1986, or
- (iii) which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act) appointed for the whole or any material part of its assets or undertaking, or
- (iv) which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act, or
- (v) which passes any resolution for winding up, or
- (vi) which becomes subject to an order of a Court for winding up.

# Annex B: Relevant legislation: the fit and proper persons tests

## Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (FPP Regulations)

5.—

1. This regulation applies where a service provider is a body other than a partnership.
2. Unless the individual satisfies all the requirements set out in paragraph (3), a service provider must not appoint or have in place an individual—
  - a. as a director of the service provider, or
  - b. performing the functions of, or functions equivalent or similar to the functions of a director.
3. The requirements referred to in paragraph (2) are that—
  - a. the individual is of good character,
  - b. the individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed,
  - c. the individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed,
  - d. the individual has not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity, and
  - e. none of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.
4. In assessing an individual's character for the purposes of paragraph (3)(a), the matters considered must include those listed in Part 2 of Schedule 4.

5. The following information must be available to be supplied to the Commission in relation to each individual who holds an office or position referred to in paragraph (2)(a) or —
  - a. the information specified in Schedule 3, and
  - b. such other information as is required to be kept by the service provider under any enactment which is relevant to that individual.
6. Where an individual who holds an office or position referred to in paragraph (2)(a) or (b) no longer meets the requirements in paragraph (3), the service provider must—
  - a. take such action as is necessary and proportionate to ensure that the office or position in question is held by an individual who meets such requirements, and
  - b. if the individual is a health care professional, social worker or other professional registered with a health care or social care regulator, inform the regulator in question.

## **SCHEDULE 4**

### **Good character and unfit person tests**

#### **PART 1**

#### **Unfit person test**

1. The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged.
2. The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.
3. The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986.
4. The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.
5. The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.
6. The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

## **PART 2**

### **Good character**

7. Whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence.
  
8. Whether the person has been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals.

# Annex C: The statutory consultation process and objection threshold

## Consultation process

The Health and Social Care Act 2012 specifies that Monitor must consult on any proposed modification to the standard conditions of the provider licence with:

- every licence holder
- the Secretary of State
- NHS England
- every CCG
- the CQC and its Healthwatch England Committee.

Monitor may only modify the standard conditions of the licence (without reference to the Competition and Markets Authority) if:

- a. No objections are received from licence holders within the notice period (a minimum of 28 days); or
- b. Where one or more licence holders object within the notice period, the objection threshold and share of supply threshold are not met.

The objection threshold is met if 20% or more licence holders object to the proposals. The share of supply threshold is met if the percentage of licence holders, weighted according to share of supply is 20% or more.

## Who can object?

All responses to the consultation will be taken into account but only objections from licence holders will count towards the objection threshold and therefore determine whether NHS Improvement can make the proposed modification without further consultation or reference to the Competition and Markets Authority.

Any objection must be made by a person who is authorised to represent the licence holder. Providers should ensure that there are proper internal processes for managing this.

Licence holders should, if they object to the proposals, provide reasons. Failure to do so will not invalidate the objection but it may have an impact on our assessment of the objection.

Contact us:

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Department  
of Health &  
Social Care

# **Integration and Innovation: working together to improve health and social care for all**

Published 11 February 2021

**The Department of Health and Social Care's legislative proposals for a Health and Care Bill**







# **Integration and Innovation: working together to improve health and social care for all**

Presented to Parliament  
by the Secretary of State for Health and Social Care  
by Command of Her Majesty

February 2021

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# Foreword

We are living through the greatest challenge our health and care system has ever faced. Yet even in crisis conditions, everyone working in our health and care system has continued to deliver excellence. Critically, collaboration across health and social care has accelerated at a pace showing what we can do when we work together, flexibly, adopting new technology focused on the needs of the patient, and set aside bureaucratic rules.

This paper sets out our legislative proposals for a Health and Care Bill. It aims to build on the incredible collaborations we have seen through Covid and shape a system that's better able to serve people in a fast-changing world.

At its heart, however, this Bill is about backing our health and care system and everyone who works in it. Our proposals build on the NHS's own – those in the Long Term Plan. We're also outlining steps to support everyone who works to meet people's health and care needs. Taken together, they will help us build back better after Covid.

First, by removing the barriers that stop the system from being truly integrated. We want to help Integrated Care Systems play a greater role, delivering the best possible care, with different parts of the NHS joining up better; and the NHS and local government forming dynamic partnerships to address some of society's most complex health problems. It will help us deliver our Manifesto Commitments, including 50,000 more nurses and 40 new hospitals.

Second, we will use legislation to remove much of the transactional bureaucracy that has made sensible decision-making harder. The reforms will help enable us to use technology in a modern way, establishing technology as a better platform to support staff and patient care. Our proposals will maintain the distinct responsibilities between those who fund services and those who provide care—which has been a cornerstone of efforts to ensure the best value for taxpayers for over thirty years—but sets out a more joined-up approach built on collaborative relationships, so that more strategic decisions can be taken to shape health and care for the decades to come. It's about population health: using the collective resources of the local system, NHS, local authorities, the voluntary sector and others to improve the health of local areas.

Finally, our proposals will ensure a system that is more accountable and responsive to the people that work in it and the people that use it. Ministers have always been accountable, rightly, for NHS performance. Our proposals will ensure NHS England, in a new combined form, is accountable to Government and the taxpayers that use it while maintaining its clinical and day-to-day operational independence. We will introduce measures to enhance quality and safety in the NHS, including the creation of an independent statutory body to oversee safety investigations. Alongside this we will work with Local Authorities to develop enhanced assurance frameworks for social care, that will support improved outcomes and experiences for people and their families.

These legislative measures are intended to support improvements already under way in the NHS. They should be seen in the context of those broader reforms. And they are by no means the full extent of this government's ambition for the nation's health. We will also bring forward changes in social care, public health and mental health. We also remain

committed to the sustainable improvement of adult social care and will bring forward proposals this year. The targeted public health interventions we have outlined here in relation to obesity and fluoridation, sit alongside our proposals for the future design of the public health system, including the creation of the National Institute for Health Protection (NIHP). We are also bringing forward legislation to bring the Mental Health Act up to date, as set out in our White Paper last month.

As we build back better after Covid-19, these proposals can help us look to the decades ahead with confidence. This is a unique moment when we must continue to build on the audacious legacy that makes the NHS the very best of Britain. We must seize it.

# 1. Executive Summary

- 1.1 We are living through the greatest challenge our health and care system has ever faced. The Coronavirus (Covid-19) pandemic caused an unprecedented external shock, bringing intense pressure that could have been devastating to the system itself and to all of us as individuals. And yet, the extraordinary dedication, care and skill of the people who work in our communities and our hospitals has been unwavering, serving as a reminder once again of just how precious our health and care services are to us all.
- 1.2 This is no ordinary moment. We have seen collaboration across health and social care at a pace and scale unimaginable even a little over a year ago. The NHS and social care providers have delivered outstanding care to those in need while at the same time radically changing ways of working, reducing bureaucracy and becoming more integrated. New teams have been built, adoption of new technology has been accelerated, new working-cultures developed, and new approaches to solving difficult problems pursued. As a result, NHS capacity grew; new hospitals were built in just a matter of days; and new ways of treating patients have become the norm. As we look towards the future and to the recovery of our society, our health and care system will continue to be central to our national wellbeing and prosperity in the years ahead.
- 1.3 In recent years, we have seen our health and care system adapt and evolve to meet the challenges facing health systems around the world. Not only is our population growing in size, people are also living longer but suffering from more long-term conditions. One in three patients admitted to hospital as an emergency has five or more health conditions, up from one in ten a decade ago. While smoking rates may be decreasing; diabetes, obesity, dementia and mental health issues are on the rise. Faced with these challenges, as well as those from Covid-19, the case couldn't be clearer for joining up and integrating care around people rather than around institutional silos – care that focuses not just on treating particular conditions, but also on lifestyles, on healthy behaviours, prevention and helping people live more independent lives for longer. We need the different parts of our health and care system to work together to provide high quality health and care, so that we live longer, healthier, active and more independent lives.
- 1.4 And so, this paper sets out our legislative proposals for a Health and Care Bill. Many of the proposals build on the NHS's recommendations in its [Long Term Plan](#), but they are also founded in the challenge outlined above. There will be those who will say that this is simply the wrong time to make any kind of change in health and social care. Even if it will help the professionals who know best to do their jobs better, unhindered by systems and processes that might slow down or even prevent them from doing their jobs in the way they would want to. The

response to Covid-19 is our current priority but we must also prepare for the recovery of our health and care system and learn lessons from this experience. Our legislative proposals capture the learning from the pandemic and are driven by the context of a post-Covid world, which is now in reach. And they make permanent the innovations that Covid-19 has accelerated and encouraged the system to improvise new and better ways of working. Our proposals will help the NHS and local government in the immediate work of recovery from the pandemic by making joint planning and delivery of services easier, and over the long term by helping to address the needs of everyone, from children to older people, at different stages of their lives.

- 1.5 We have seen the brilliance of our doctors, nurses, carers and other healthcare professionals in providing world-class care to those in need. What has gone unseen by many is that in order to provide this level of care the traditional dividing lines between health professionals have been cast aside to allow unprecedented levels of collaboration.
- 1.6 If we are to improve the lives and life-chances of all in this country, no matter where they are from, their ethnicity or social background we must be ready for whatever may come next.
- 1.7 The response to Covid-19 - led by those who know best - has shown us new ways to deliver care using innovative and creative solutions, exploiting the potential of digital and data, instead of needless bureaucracy. We must not go back to the old ways of working. The gains made through these new approaches must be locked in.
- 1.8 The founding principles of the NHS – taxpayer-funded healthcare available to all, cradle-to-grave, and free at the point of delivery – remain as relevant now as they were in 1948. Local government delivery is also rooted in firm foundations: in serving its residents, with strong local democratic accountability, and expertise in the health, public health and care needs of its populations. To protect these principles, which are so close to all our hearts, we must back those who make them a reality every day of their lives - by building and constantly renewing a culture of collaboration.
- 1.9 Integrating care has meant more people are seeing the benefits of joined up care between GPs, home care and care homes, community health services, hospitals and mental health services. For staff, it has enabled them to work outside of organisational silos, deliver more user-centred and personalised approaches to care, and tackle bureaucracy standing in the way of providing the best care for people. It enables greater ambition on tackling health inequalities and the wider determinants of health – issues which no one part of the system can address alone. It both relies on the power of digital and data to join up care and uses that



power to drive transformation of care. The experience of the pandemic has made the case for integrated care even stronger and has redoubled the government's determination to ensure that public health, social care and healthcare work more closely together in the future than ever before.

- 1.10 High-performing teams and organisations have vibrant cultures that create the conditions for people to perform at their very best. They are collaborative and open organisations, people focussed with processes that support rather than suffocate the efforts of individuals to do good work. And so, this White Paper sets out our proposals for legislation to support and enable the health and care workforce, organisations and wider system to work together to improve, integrate and innovate.
- 1.11 In this paper we refer to health and care partners for brevity's sake, but to be clear, we believe that this means everyone who works tirelessly to deliver high-quality care and support to people all over the country, including NHS organisations, local authorities, voluntary partners and charities.

## **Working together to integrate care**

- 1.12 At the heart of the changes being taken forward by the NHS and its partners, and at the heart of our legislative proposals, is the goal of joined up care for everyone in England. Instead of working independently every part of the NHS, public health and social care system should continue to seek out ways to connect, communicate and collaborate so that the health and care needs of people are met. Healthy, fulfilled, independent and longer lives for the people of England will require health and care services, local government, NHS bodies, and others to work ever more closely together. Different professions, organisations, services and sectors will work with common purpose and in partnership. This will be especially important when we seek to focus on the people and communities that are most in need of support.
- 1.13 There are, then, two forms of integration which will be underpinned by the legislation: integration within the NHS to remove some of the cumbersome boundaries to collaboration and to make working together an organising principle; and greater collaboration between the NHS and local government, as well as wider delivery partners, to deliver improved outcomes to health and wellbeing for local people.
- 1.14 The NHS and local authorities will be given a duty to collaborate with each other. We will also bring forward measures for statutory Integrated Care Systems (ICSs). These will be comprised of an ICS Health and Care Partnership, bringing together the NHS, local government and partners, and an ICS NHS Body. The ICS NHS

body will be responsible for the day to day running of the ICS, while the ICS Health and Care Partnership will bring together systems to support integration and develop a plan to address the systems' health, public health, and social care needs. Both bodies will need to draw on the experience and expertise of front-line staff across health and social care. The legislation will aim to avoid a one-size-fits-all approach but enable flexibility for local areas to determine the best system arrangements for them. A key responsibility for these systems will be to support place-based joint working between the NHS, local government, community health services, and other partners such as the voluntary and community sector. Frequently, place level commissioning within an integrated care system will align geographically to a local authority boundary, and the Better Care Fund (BCF) plan will provide a tool for agreeing priorities. This will be further supported by other measures including improvements in data sharing and enshrining a 'triple aim' for NHS organisations to support better health and wellbeing for everyone, better quality of health services for all, and sustainable use of NHS resources.

## **Reducing bureaucracy**

- 1.15 Stakeholders have said that existing legislation is overly detailed and prescriptive in some areas. We intend to reform the existing legislation to support the workforce by creating the flexibility NHS organisations need – to remove the barriers that prevent them from working together and to enable them to arrange services and provide joined up care in the interests of service users. We will put pragmatism at the heart of the system. Enabling the NHS and local authorities to arrange healthcare services to meet current and future challenges by ensuring that public and taxpayer value – and joined up care – are first and foremost. This will require changes to both competition law as it was applied to the NHS in the Health and Social Care Act 2012 and the system of procurement applied to the NHS by that legislation. These changes will enable the NHS and local authorities to avoid needless bureaucracy in arranging healthcare services while retaining core duties to ensure quality and value. This will be supported by further pragmatic reforms to the tariff and to remove the statutory requirement for Local Education and Training Boards.

## **Improving accountability and enhancing public confidence**

- 1.16 We are also bringing forward several measures to improve accountability in the system in a way that will empower organisations and give the public the confidence that they are receiving the best care from their health and care system, every time they interact with it. The de facto development in recent years of a strongly supportive national NHS body in the form of a merged NHS England and NHS Improvement will be placed on a statutory footing and will be designated as

NHS England. This will be complemented by enhanced powers of direction for the government over the newly merged body which will support great collaboration, information sharing and aligned responsibility and accountability. In addition, we will legislate to further ensure the NHS is able to respond to changes and external challenges with agility as needed. Measures will include reforms to the mandate to NHS England to allow for more flexibility of timing; the power to transfer functions between Arm's Length Bodies and the removal of time limits on Special Health Authorities. An improved level of accountability will also be introduced within social care, with a new assurance framework allowing greater oversight of local authority delivery of care, and improved data collection allowing us to better understand capacity and risk in the social care system. Our measures recognise this, and we therefore plan to introduce greater clarity in the responsibility for workforce planning and a clear line of accountability for service reconfigurations with a power for ministers to determine service reconfigurations earlier in the process than is presently possible.

## **Additional measures**

- 1.17 We also intend to bring forward other measures to support social care, public health and the NHS. These are designed to address specific problems or remove barriers to delivery, maximise opportunities for improvement, and have in most cases been informed by the experience of the pandemic.
- 1.18 These measures are not intended to address all the challenges faced by the health and social care system. The government is undertaking broader reforms to social care and public health which will support the system in helping people to live healthier, more independent lives for longer. In particular, the Department recognises the significant pressures faced by the social care sector and remains committed to reform. We want to ensure that every person receives the care they need and that it is provided with the dignity they deserve. We have committed to bringing forward proposals this year but, in the meantime, our legislative proposals will embed rapid improvements made to the system as it has adapted to challenges arising from Covid-19. Similarly, on public health, our experience of the pandemic underlines the importance of a population health approach, informed by insights from data: preventing disease, protecting people from threats to health, and supporting individuals and communities to improve their health and resilience. The government will publish in due course an update on proposals for the future design of the public health system, which will create strong foundations for the whole system to function at its best. But the measures in this legislation will address issues that require intervention through primary legislation.
- 1.19 In social care, we have set out a number of measures that apply the core themes of these proposals set out above in the specific context of social care. Integration

will be enhanced through the position of social care in the ICS structure, a new standalone legal basis for the Better Care Fund and allowing 'Discharge to Assess' models to be followed. A legal power to make direct payments to providers will reduce bureaucracy in providing future additional support to the sector. Finally, an enhanced assurance framework and improved data collection will improve accountability within the social care sector.

- 1.20 For public health, alongside the population health element of our "triple aim", we intend to bring forward measures to: make it easier to secure rapid change updates in NHS England public health functions; help tackle obesity by introducing further restrictions on the advertising of high fat, salt and sugar foods; as well as a new power for Ministers to alter certain food labelling requirements. In addition, we will be streamlining the process for the fluoridation of water in England by moving responsibilities for doing so from local authorities to central government.
- 1.21 Finally, we plan to bring forward measures that contribute to improved quality and safety in the NHS, including placing the Health Services Safety Investigations Body on a statutory footing; establishing a statutory medical examiners system; and allowing the Medicines and Healthcare products Regulatory Agency to set up national medicines registries. We are also putting in place legislation to enable the implementation of comprehensive reciprocal healthcare agreements with countries around the world.

## **Next steps**

- 1.22 As we set out in chapter one, legislation is best seen as an enabler of change that is most effective when combined with other reforms and drivers of change within the health and care system. We have seen the NHS adapt in recent years, developing innovations to support more joined up care and to tackle bureaucracy. This provides a foundation to build upon and our aim is to use legislation to provide a supportive framework for health and care organisations to continue to pursue integrated care and other sources of value for service users and taxpayers in a pragmatic manner. As the system emerges from the pandemic, these legislative measures will assist with recovery by bringing organisations together, removing the bureaucratic and legislative barriers between them and enabling the changes and innovations they need to make.
- 1.23 On current timeframes, and subject to Parliamentary business, our plan is that the legislative proposals for health and care reform outlined in this paper will begin to be implemented in 2022. This means they will form a critical part of the recovery process from the pandemic, and so we must ensure that our approach is enabling and flexible. Many of the lessons of the pandemic are clear, but it will take time to fully understand them all. We need to combine the realism required in recognising

we do not know all the answers with the urgency of working to successfully apply the insights we do have as soon as possible. Legislation can only ever be part of the picture, and will need to support and accompany wider reforms in areas such as data and finance, which will play a key role in the years ahead to meet the changing needs of the population, to deal with the challenges caused by the pandemic, and to tackle the health inequalities exposed by Covid-19.

## 2. The role of legislation

- 2.1 In a typical 24-hour period, the NHS in England will see 1 million patients in GP appointments and carry out over 26,000 operations. In the social care system, local authorities are supporting almost 150,000 older people and over 40,000 young people in care homes as well as over 440,000 people in the community. Councils received 1.9m requests for adult social care support in 2019/20 – equivalent to 5,290 requests for support per day. Behind those numbers there are many stories of hope, vulnerability, care and healing; and of health and care services that have empowered and helped people to live fulfilling lives. These stories are the work of the dedicated staff who make our NHS and our care system what it is, and the real experiences of the people behind the statistics.
- 2.2 How many of those health and care staff on that typical day consult, discuss or even think about the legal framework the health and care system operates within? Or how many people are aware of the patchwork of legislation that applies to the NHS and social care system? Hardly any, of course, and there is no reason why they should. The legal framework for the health and care system should be like any operating system – the sort of thing you tend not to notice when it is working well.
- 2.3 It is, however, clear that some elements of the current legal framework need to be improved. The lessons from the pandemic cannot and should not be ignored, we need the right legislative framework to support the recovery by improving outcomes, reducing health inequalities and making best use of limited resources. Society's health and care needs are changing. People are living longer; over the next 20 years the population in England is expected to grow by almost 10%, with the number of people aged 75+ expected to grow by almost 60% - an additional 2.7 million people. New medicines and technologies are being discovered, and more of us are living with long-term conditions such as diabetes or asthma. The proportion of people aged 65+ with four or more diseases is set to almost double by 2035, with around a third of these people having a mental health problem. Covid-19 has exacerbated these trends. Our health and care system will continue to adapt and evolve, as it always has, to meet the challenges of the future and recover from the pandemic. As such, the legislative framework needs to recognise these increasingly complex needs, provide flexibility and support for the health and care system, and ultimately act as a key enabler to support and sustain the process.

**Some of the challenges we face**

- **NHS activity has grown every year since records began** (at an average of 3.3% a year). Over the last 9 years (between 2009/10 and 2018/19) the number of attendances in A&E increased by 4.3 million; the number of GP appointments have risen from 222 million in 1995 to 308 million in 2018/19; and the number of outpatient attendances has increased by almost 36 million since 2009/10.
- **Social care too has seen activity grow.** In 2019/20, there were 1.9 million requests for adult social care support from new clients, an increase of 6% since 2015/16.
- **A growing and ageing population.** Over the next 20 years the population in England is expected to grow by almost 10%. The number of people aged 75+ is expected to grow by almost 60% - an additional 2.7 million people.
- **Growing morbidity and complexity of disease.** Around 20% of our lives are spent in poor health, which has been increasing in recent years and is likely to continue in future. The proportion of people aged 65+ with four or more diseases is set to almost double by 2035, with around a third of these people having a mental health problem.
- **Medical care advancements and technological innovations.** As medical care advances there are more treatments available and more conditions can be treated.
- **Covid-19.** Covid will continue to cause innumerable short, medium and long-term effects to healthcare in the UK and has shone a spotlight on inequalities.

## Achievements

- **Improvements in health outcomes.** Life expectancy at birth in the UK is above the OECD average at 81.4. Death rates from cardiovascular disease have fallen by 60% since 1990 in England, compared to c.50% in the OECD. The UK has the 4th lowest adult diabetes prevalence rate amongst OECD countries.
- **Quality of care improvements.** As of 2020, around 94% of GP practices rated good or outstanding by the Care Quality Commission (CQC), around 82% for NHS mental health core services and 85% of adult social care providers.
- **Safety.** The UK is recognised internationally as a world-leader in driving the patient safety agenda in healthcare.
- **Covid-19 response.** As of 9 February 2021, the UK has vaccinated 12.6 million people. In the early stages of the response, the NHS COVID-19 Data Store was established, which safely brought together accurate, real-time information necessary to inform decisions in response to the current pandemic in England.

- **Building infrastructure for the future.** In October the government announced the creation of 40 hospitals and a further competition for 8 new schemes for competition by 2030.

- 2.4 A great deal of the changes required were captured in the [NHS's recommendations](#) to Government and Parliament for an NHS Bill. These described the legislative changes the NHS needed to help it to deliver the improved outcomes set out in the [NHS Long Term Plan. Both these documents were published with](#) broad support in 2019.
- 2.5 Legislative change can bring real benefits when it helps to remove barriers, provide flexibility and clarify roles. That is precisely what we are seeking to do with these proposals. The measures outlined in this document are designed to make it easier for NHS organisations and their partners to work together to tackle the issues that matter most to the people they serve; to help them move from being 'importers of illness to exporters of health' to quote former Chief Medical Officer Sally Davies<sup>1</sup>. Legislation can help to create the right conditions, but it will be the hard work of the workforce and partners in local places and systems up and down the country that will make the real difference. This does not just apply to legislation for the NHS, and we have sought to develop our legislative proposals with the whole of the health and care system in mind.
- 2.6 A central theme in the NHS's own Long Term Plan is the importance of joint working with colleagues in local government and elsewhere. It is clear that neither the NHS nor local government can address all the challenges facing whole population health on their own. The ambition to reduce inequalities and support people to live longer, healthier and more independent lives will demand bold, joint and cohesive efforts. As well as closer working at a local place and system level, in some cases proportionate national legislative intervention on public health measures must play its part.
- 2.7 We also recognise that the social care system needs reform: this remains a manifesto commitment and the government intends to bring forward separate proposals on social care reform later this year. No one piece of legislation can fix all the challenges facing health and social care – nor should it try – but it will play an important role in meeting the longer-term health and social care challenges we face as a society.
- 2.8 In bringing forward these measures, we are determined to make the changes to legislation the NHS asked for and, given the government's wider responsibilities for public health and social care, we intend to take forward a set of targeted

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<sup>1</sup> Sally C Davies and Jonathan Pearson-Stuttard, *Whose Health Is It*, Anyway, pp7-8.



legislative measures to support social care, public health and safety and quality. These proposals capture the initial learning from the experience of the health and care system in responding to the pandemic and make permanent some of the innovations where Covid-19 has accelerated new and better ways of working. They provide a framework which allows further evolution and will support, harness and sustain the collaboration and integration seen during Covid-19.

- 2.9 Legislation of all kinds needs to be carefully calibrated to make only necessary and proportionate changes. The risk of legislative overreach and of an excessive specification of detail, spelling out the exact conditions under which specific organisations can and cannot work together, can lead to burdensome bureaucracy and confusion for those faced with the task of implementation. As the pandemic has shown, there is a great deal of insight, commitment and innovation in local organisations. We need a legislative framework that builds on the trust we have for those within systems to understand and deliver what their populations need.
- 2.10 Integration is a good example of this: we can legislate to make it easier to integrate care, but it is the hard work of local organisations that make integration a reality. To face the challenges facing the health and care system described above, local authorities, different parts of the NHS – hospitals, primary care, mental health teams and others – and care homes are working together more closely than ever before. In so many areas integration and coordination of services to keep people healthy and out of hospital, is already happening. Even before the pandemic, many local system leaders were seeing huge benefits from joining up across health and local authorities. The NHS and local authorities are working together to make the move from hospital to care settings more seamless for individuals. The NHS and Directors of Public Health are working together to develop more sophisticated approaches to population health management. And local organisations are working together to address the more intractable challenges associated with the wider determinants of health which are best solved when the NHS and local authorities work as a team to support an individual's physical, mental, social and economic needs. It is clear from these examples that the culture of the health and care system is changing and there is a strong recognition across organisations that joined up care and partnership working is critical to ensure better and fairer health for people in England in the years and decades ahead. We will want to engage closely with the system as we develop our implementation plans.

The road to better coordination of health and care

- 2014: NHS and local government's national leaders set out a vision of more collaboration in the NHS *Five Year Forward View*

- 2015: 'Vanguards' in 50 areas began to develop and test new models of care
- 2016: NHS and local councils formed Sustainability and Transformation Partnerships covering all of England, to consider local health and care priorities and to plan services together
- 2017: areas refined initial proposals, drawing on conversations with frontline staff, local residents and others in the community
- 2018: some partnerships began to take on more responsibility by becoming 'integrated care systems'
- 2019: NHS Long-Term Plan confirmed that every area will be served by an integrated care system by 2021, with primary and community services funded to do more
- 2020: Building on previous publications for legislative reform, NHS England set out details for how systems will accelerate collaborative ways of working in the future, considering the key components of an effective integrated care system (ICS) and reflecting what a range of local leaders have said about their experiences during the last two years, including the immediate and long-term challenges presented by the Covid-19 pandemic
- 2021: NHS England response to the ICS consultation document and the government brings forward legislative proposals to support integration

2.11 Our proposals will help to create a new framework that builds on the changes already made by the health and care system itself and which will better enable the system to tackle the challenges of the future. Beyond the legislative proposals set out in this document, there are several other ongoing developments and changes to the health and care system – including the development of a data strategy for health and social care, which will capture and build on the lessons of our COVID response and set the direction for data in a post-pandemic system, ensuring that the power of data, used properly, is able to support the transformation of care; financial arrangements to support integration and improvements to public health services – that our proposals are designed to support and to align with. An outward-looking, more connected and integrated health and care system focused on population health, public wellbeing and where technology enabled innovation is possible, and we know it is possible because it is already happening in lots of places. Our proposals are designed to enhance, support, spread and encourage the changes that are already underway to make joined up care a reality for all.

## 3. Our proposals for legislation

- 3.1 Many of the measures we are proposing have been under consideration for some time. In January 2019, the NHS published its [Long Term Plan](#) which set out the priorities for health and care over the next ten years. This plan, developed in partnership with those who know the NHS best – frontline health and social care staff, patients and their families and other experts - suggested targeted legislative proposals that would help to support the implementation of the objectives described in the Long Term Plan.
- 3.2 Following the publication of the Long Term Plan proposals for legislation, 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. There were more than 190,000 responses to this engagement exercise and in September 2019, [NHS England published their final recommendations](#). A number of influential organisations and individuals wrote to the government in broad support. These recommendations were supported in a [letter to government](#), including NHS Providers, Unison, the Local Government Association, the Academy of Medical Royal Colleges, National Voices and others.
- 3.3 NHS England’s proposals form the foundation of this Bill. Their recommendations for legislation were designed around three important principles that still stand today: any legislation should solve practical problems; avoid a disruptive top down reorganisation; and have broad consensus within the system. The majority of our proposals either directly implement or build upon NHS England’s recommendations. Where we have built upon NHS England’s proposals this is because we have explored some developments since the original NHS England publication and the experience of Covid-19 suggests there is a case to go further to reach our objective.
- 3.4 In light of this experience of dealing with the pandemic, we have also added some additional proposals in a number of key areas that fall within the broader remit of the Secretary of State for Health and Social Care. These proposals relate to public health, social care and quality and safety matters. These proposals are not intended to add up to a coherent reform package in themselves, rather they represent a specific set of proposals where change to primary legislation is required. But they are intended to complement a much wider package of reforms in social care, public health and mental health. Whilst the majority of these proposals are England only, in some case they would apply to the Devolved Administrations (DAs). We will continue to engage with DAs on all the proposals in this paper. As stated above, it is important that this legislation responds to the NHS’s asks of government, but it is also important that the legislation looks beyond just the NHS, to the whole health and care system, to ensure that

together, the system can deliver improved outcomes for the people who rely on it. Whilst this legislation is not the vehicle for wholesale social care or public health reform, we have sought to use it to address specific problems, where legislative change could be beneficial.

- 3.5 In forming our proposals, we have been able to draw upon the work done by NHS England as part of its Long Term Plan process and upon the insights generated by the extensive engagement that NHS England undertook in formulating its proposals. We have supplemented this with a number of further engagement conversations with stakeholders on both specific issues and on the wider lessons of both the pandemic and the more evolutionary changes experienced by the health and care system in recent years. See Annex C for a list of stakeholders that the Department has been engaging with.
- 3.6 The proposals we have developed can be grouped under the following themes: working together and supporting integration; stripping out needless bureaucracy; enhancing public confidence and accountability; and additional proposals to support social care, public health, and quality and safety. The full detail of these proposals can be found in Annex A. The first three themes directly implement or build on the proposals made by NHS England to government as part of its 2019 engagement exercise on legislative proposals. The final theme includes additional proposals that DHSC consider appropriate to bring forward in this Bill, in light of the experience of the pandemic, and the desire to support the health and care system to recover and reform.

## **Working together and supporting integration**

### **Enabling different parts of the health and care system to work together effectively, in a way that will improve outcomes and address inequalities**

Working together and supporting integration proposals:

1. Integrated Care Systems
2. Duty to Collaborate
3. Triple Aim
4. Foundation Trusts Capital Spend Limits
5. Joint committees

6. Collaborative Commissioning
7. Joint Appointments
8. Patient Choice
9. Data Sharing

- 3.7 Covid-19 has demonstrated the importance of different parts of the health and care system working together in the best interests of the public and patients. This has been something that organisations in the health and care system have been increasingly working towards over the past few years, despite the barriers in legislation which sometimes make it difficult to do so. We propose to implement NHS England's recommendations and legislate to support integration, both within the health service, and between the health service and local government, with its statutory responsibilities for public health and social care.
- 3.8 We want to legislate for **every part of England to be covered by an integrated care system (ICS)**. This builds on the work the system has been doing since the publication of the NHS Long Term Plan, and is in line with NHS England's recommendation in their recent document, formally recognising the need to bring together NHS organisations, local government and wider partners at a system level to deliver more joined up approaches to improving health and care outcomes, coterminous with local authorities.
- 3.9 We intend to establish a statutory ICS in each ICS area. These will be made up of an ICS NHS Body and a separate ICS Health and Care Partnership, bringing together the NHS, local government and partners. The ICS NHS body will be responsible for the day to day running of the ICS, while the ICS Health and Care Partnership will bring together systems to support integration and develop a plan to address the systems' health, public health, and social care needs. Both bodies will need to draw on the experience and expertise of front-line staff across health and social care. ICSs will be accountable for outcomes of the health of the population and we are exploring ways to enhance the role of CQC in reviewing system working
- 3.10 We know from the vanguard ICSs that taking a joined-up, population focused approach means you cannot see the people that services are meant for as just units within the system – their voice and sense of what matters to them becomes really central. That focus won't come through structures alone of course but working with organisations such as Healthwatch there is a real chance to strengthen and assess patient voice at place and system levels, not just as a commentary on services but as a source of genuine co-production.

- 3.11 This will be supported by a broad **duty to collaborate** across the health and care system and a **triple aim duty** on health bodies, including ICSs, as recommended by NHS England. This will require health bodies, including ICSs, to ensure they pursue simultaneously the three aims of better health and wellbeing for everyone, better quality of health services for all individuals, and sustainable use of NHS resources. As an additional safeguard for financial sustainability, we will take a power to impose **capital spending limits on Foundation Trusts**, in line with NHS England’s recommendation. We will implement NHS England’s recommendations to **remove barriers to integration through joint committees, collaborative commissioning approaches and joint appointments**, as well as their recommendation to preserve and strengthen the right to **patient choice** within systems. We will also legislate to ensure more **effective data sharing** across the health and care system, which is critical to effective integration, and will enable the digital transformation of care pathways. Separately set out proposals relating to Adult Social Care also contribute to our ambitions in this area, including reconfirming the legal basis of the Better Care Fund, and changes to the legal functioning of the Better Care Fund, and changes to processes around discharge and assessment.
- 3.12 Further detail on our proposals for integrated care systems is set out at Annex B, encompassing both the legislative and the non-legislative arrangements we intend to put in place. This is one of the most important elements of the legislative proposals, and we have sought to understand the hopes and concerns of a range of stakeholders in framing them. We have been particularly mindful of the importance of places within systems and of the enormous potential for joint working and innovation between local government and health partners that many of the vanguard ICSs have already demonstrated, while also recognising the distinct accountabilities of NHS bodies and local government.

## Reducing bureaucracy

**Turning effective innovations and bureaucracy busting into meaningful improvements for everyone, learning from innovations during Covid-19.**

### Reducing Bureaucracy proposals:

1. Competition
2. Arranging healthcare services
3. National Tariff

#### 4. New Trusts

#### 5. Removing Local Education Training Boards (LETBs)

3.13 In line with NHS England's recommendations, we wish to build greater flexibility into the basis provided by the 2012 legislation, where the current framework fails to enhance and streamline accountability, or necessitates complex or bureaucratic workarounds and makes it difficult for the system to integrate and adapt over time as needed. Covid-19 has presented a unique opportunity and imperative to drive real change in this area, building on the innovation and cultural shift that was already underway in many places. When the pandemic struck, the NHS, the social care sector and partners were quick to cut through some of the bureaucracy that had accumulated over a number of years. Whether it was in relation to data sharing, flexible workforce deployment, decision making / governance, or integrated delivery; in many parts of the country, system leaders responded swiftly to the challenges of the pandemic. Whilst some of these changes are only appropriate as part of an emergency response, others demonstrated how new ways of working could lead to better outcomes in more normal times. We need to build on the trust that we know we can place on frontline staff and their organisations, to enable them to deliver better outcomes and experiences for people that use health and care services.

#### **Busting Bureaucracy: optimising data requests and data sharing**

The pandemic saw the suspension of certain data collection requests from government and national bodies such as NHS England, NHS Digital and the Care Quality Commission. Where data collection was vital to the pandemic response, existing powers were used to publish notices requiring health and care bodies to share data to help manage and control the spread of Covid-19 within local systems. We will build on this approach and make changes to the regulations governing the sharing of data to enable more effective use of data for the benefit of individuals and the health and care system as a whole.

3.14 The Department of Health and Social Care's paper, [Busting bureaucracy: empowering frontline staff by reducing excess bureaucracy in the health and care system in England](#), sets out the government's strategy for reducing excess bureaucracy. These actions are being taken forward through a variety of different projects, some led by the department, some by regulators and some by other bodies across the health and care system. Whilst we can do a lot to reduce bureaucracy through changing processes and culture, the Department's engagement demonstrated that a lot of bureaucracy is also generated by the legislation which in some places is no longer fit for purpose and we therefore want to use this opportunity to amend legislation to resolve these issues.

3.15 In line with the requests made by the NHS, we will use legislation to remove much of the transactional bureaucracy that has made sensible decision-making in the system harder. The NHS should be **free to make decisions on how it organises itself without the involvement of the Competition and Markets Authority (CMA)**. We will also **reform how health care services are arranged by creating a bespoke health services provider selection regime** that will give commissioners greater flexibility in how they arrange services than at present. The NHS have committed to consulting on the new regime. Where procurement processes can add value they will continue, but that will be a decision that the NHS will be able to make for itself. These changes retain a division of responsibility between strategic planning and funding decisions on the one hand, and care delivery on the other, but allow for its operation in a more joined up way. We will preserve the division between funding decisions and provisions of care. These new flexibilities will be **reinforced by changes to the tariff to enable the tariff to work more flexibly within system approaches**; and giving the Secretary of State the **power to create New Trusts to ensure alignment within an integrated system** where that is helpful. In line with the aim of reducing the need for bureaucratic workarounds, and increasing flexibility and adaptability in the system, the government is also proposing an additional measure not put forward by NHS England in their paper: the **removal of Local Education Training Boards (LETBs) from statute** to give Health Education England (HEE) more flexibility to adapt its regional operating model over time. For social care, we also proposed introducing a new legal power to make payments directly to social care providers to remove barriers in making future payments to the sector.

## Enhancing public confidence and accountability

**Ensuring that we have the right framework for national 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**

### Ensuring accountability and public confidence proposals:

1. Merging NHS England, Monitor and the NHS Trust Development Authority and Secretary of State powers of direction
2. The NHS Mandate
3. Reconfigurations intervention power
4. Arm's Length Bodies (ALB) Transfer of Functions



## 5. Removing Special Health Authorities Time Limits

## 6. Workforce Accountability

- 3.16 Both the public and Parliament rightly expect to be able to hold decision makers who oversee the health and care system to account. Our legislative proposals focus on ensuring that our accountability arrangements command public confidence, whilst also enabling systems to get on with doing their jobs and making appropriate changes to enable transformation and innovation. This means ensuring that the framework for national oversight of the NHS is fit for purpose now and into the future.
- 3.17 The original set of national NHS bodies has already altered in form and purpose, and in the proposed legislation, we intend to continue the work already undertaken to **formally bring together NHS England and NHS Improvement into a single legal organisation.**
- 3.18 The public largely see the NHS as a single organisation and as local health systems work more closely together, the same needs to happen at a national level. Recognising the evolution of NHS England, we are **also bringing forward a complementary proposal to ensure the Secretary of State for Health and Social Care has appropriate intervention powers** with respect to relevant functions of NHS England. This will support the Secretary of State, when appropriate, to make structured interventions to set clear direction, support system accountability and agility, and also enable the government to support NHS England to align its work effectively with wider priorities for health and social care. This will serve, in turn, to reinforce the accountability to Parliament of the Secretary of State and government for the NHS and the wider health and care system.
- 3.19 Furthermore, the pandemic has highlighted the need to balance national action with local autonomy. The evolution of the system in recent years has led to greater level of responsibility being held by NHS England and NHS Improvement. As Integrated Care Systems are established, we expect more of that responsibility to be held by ICSs themselves. This will be accompanied by measures to strengthen and clarify the role of government and Parliament. The Department will also have a critical role to play in overseeing the health and care system and in ensuring strong alignment and close working between public health, healthcare and social care.
- 3.20 The Department will support the independence and accountability of ICSs, and the Secretary of State for Health and Social Care will have an important role in ensuring that integration across health, public health and social care is working

effectively within these systems. This will be enabled by a **more flexible mandate for NHS England**, which will make it easier for the Secretary of State to set objectives for the body. In addition, when it comes to significant service change, some Parliamentarians have criticised the current system for a lack of accountability and timely access to decision-making for them and the people they represent. We therefore intend to include a provision to allow the Secretary of State to **intervene in local service reconfiguration changes** where required.

- 3.21 We also intend to **legislate to ensure a more agile and flexible framework for national bodies that can adapt over time**. There are no current plans to change or transfer functions of the bodies in the system (with the exception of the changes we are making to merge NHS England and NHS Improvement, and changes arising from the establishment of the National Institute for Health Protection and related reforms to the public health system). Almost half of respondents agreed to this proposal in NHS England’s consultation. The government is proposing additional safeguards, which will enable further scrutiny if this power is used. The government is also proposing to bring forward measures to **remove the 3-year time limit for Special Health Authorities from legislation**. Whilst not specifically considered in NHS England’s previous recommendations, it is a measure which will support a more flexible framework for national bodies and remove unnecessary limitations from the legislation.
- 3.22 Set out in more detail below, we also intend to legislate to improve accountability in the social care sector. An enhanced assurance framework will provide a greater level of oversight of the delivery of social care by local authorities. At the same time improved data collection will improve insight into the functioning of the sector.
- 3.23 Finally, we are proposing to introduce a Secretary of State duty to publish a report every Parliament which will support **greater clarity around workforce planning responsibilities**, which reflects the concerns raised by the Royal College of Nursing in response to NHS England’s publication and will support the aim of greater clarity in how national bodies operate.

## Additional proposals

### Supporting social care, public health and quality and safety

#### Additional proposals:

##### Social Care

1. Assurance

2. Data
3. Direct payments to providers
4. Discharge to assess
5. A standalone power for the Better Care Fund

#### Public health

6. Public Health power of direction
7. Obesity
8. Fluoridation

#### Safety and Quality

10. Health Services Safety Investigations Body (HSSIB)
11. Professional Regulation
12. Medical Examiners
13. Medicines and Healthcare products Regulatory Agency (MHRA) new national (UK wide) medicines registries
14. Hospital food standards
15. Reciprocal healthcare agreements with Rest of World countries

3.24 We have developed an additional series of targeted proposals which will improve social care, public health and quality and safety. These complement the measures we are putting in place in response to the NHS's requests to government. The proposals are not intended to form a coherent reform package in themselves (as stated above, reforms to social care and public health will be dealt with outside this Bill), but are intended to address specific problems or remove barriers to delivery, maximise opportunities for improvement, and have in some cases been informed by the experience of the pandemic.

- 3.25 On social care: we intend to bring forward proposals to reflect the themes of supporting integration, reducing bureaucracy and improved accountability in a manner that addresses the specific needs of the social care sector. We will bring forward **measures on system assurance and data**, to ensure that there are appropriate levels of oversight on the provision and commissioning of social care; a payment power, which corrects a limitation in existing legislation preventing the Secretary of State for Health and Social Care making **emergency payments directly to all social care providers**; and proposals that provide greater flexibility as to at what point assessments for care can be made. We will also create a **standalone power for the Better Care Fund**, separating it from the NHS mandate setting process.
- 3.26 On public health we will bring forward measures to: make it easier for the Secretary of State to direct NHS England to **take on specific public health functions**; help **tackle obesity by introducing further restrictions on the advertising of high fat, salt and sugar foods**; as well as a new power for ministers to alter certain **food labelling requirements**. This will ensure consumers can be supported to make more informed, healthier choices about their food and drink purchases. In addition, we will be **streamlining the process for the fluoridation of water** in England by moving the responsibilities for doing so, including consultation responsibilities, from local authorities to central government. These public health measures will complement and augment the efforts of ICSs to make real inroads in improving population health in their areas, helping to tackle inequalities and 'level-up' across communities.
- 3.27 On safety and quality: we will bring forward measures to **put the Healthcare Safety Investigation Branch (HSIB) on a statutory footing**; to enable us to **improve the current regulatory landscape for healthcare professionals** as needed; to **establish a statutory medical examiner system** within the NHS for the purpose of scrutinising all deaths which do not involve a coroner and increase transparency for the bereaved, and to **allow the Medicines and Healthcare products Regulatory Agency (MHRA)** to develop and maintain publicly funded and operated medicine registries so that we can provide patients and their prescribers, as well as regulators and the NHS, with the evidence they need to make evidence-based decisions. We will also be bringing forward measures to enable the Secretary of State to **set requirements in relation to hospital food**. And finally, we will take powers to **implement comprehensive reciprocal healthcare agreements with countries outside the EEA and Switzerland** ('Rest of World countries') – expanding our ability to support the health of our citizens when they travel abroad, subject to bilateral agreements.

## 4. Delivering for patients, citizens and local populations - supporting implementation and innovation

- 4.1 This White Paper represents a significant milestone on the journey towards achieving our objective of supporting everyone to live healthier and fulfilling lives for longer.
- 4.2 For people using the NHS regularly, our proposals will support their GP and healthcare specialists to work together to arrange treatment and interventions that either prevent illness or prevent their conditions deteriorating into acute illness. This population health approach will be informed by better data and understanding of local populations, identifying those who are at risk and who we can impact, with a view to designing a more proactive way of planning and delivering care. It will mean that social care providers can receive emergency financial support when needed to prevent instability in care for the most vulnerable people in our communities. For staff working across the NHS, public health and social care, it should mean that there are fewer bureaucratic hurdles to overcome when they are just trying to do their job. It will support hospitals, GPs, local authorities and voluntary partners to work together to plan how they will address the health needs of their populations in the years ahead, including the use of technology, so that over time the people we care for can live healthier lives for longer. And it will ensure that the quality and safety of care continues to improve, through enhanced use of data, with investigations of things that go wrong so mistakes can be learned from.

“But no one recognises more than does the Government, and certainly no one recognises more than I do, that no legislation, however wisely conceived and however efficiently embodied in an Act of Parliament, can ever give the public a great health service unless the people who administer it want to do it and are enthusiastic in doing it” – Aneurin Bevan, [1946](#)

- 4.3 However, bringing forward legislation is only part of the story. Our proposals are designed to support and accelerate positive changes within the system – its adaptability, collaborative instincts and its ability and determination to always find a way. The measure of the success of legislative change will not be the permanent casting of the system in a single form, but instead the acceleration of its ability to learn, adapt and improve. This will also require the use of non-legislative means, including having the right workforce in place; good leadership at all levels, setting out clear guidance; and getting the incentives and financial flows

right. In order to be successful, our proposals will therefore be supported by an implementation programme that recognises the importance of key non-legislative enablers in facilitating change. We will work closely with the health and care system in developing this implementation programme.

4.4 This legislation is not intended to address all the challenges faced by the health and social care system. The government is undertaking broader reforms to social care, public health and mental health which will support the system in helping people to live healthier, more independent lives for longer.

- (a) The Department recognises the significant pressures faced by the social care sector and remains committed to reform. We want to ensure that every person receives the care they need and that it is provided with the dignity they deserve. Our objectives for social care reform are to enable an affordable, high quality and sustainable adult social care system that meets people's needs, whilst supporting health and care to join up services around people. We have committed to bringing forward proposals this year but, in the meantime, our legislative proposals will embed rapid improvements made to the system as it has adapted to challenges arising from Covid-19.
- (b) Our experience of the pandemic underlines the importance of a population health approach: preventing disease, protecting people from threats to health, and supporting individuals and communities to improve their health and resilience. The government will publish in due course an update on proposals for the future design of the public health system, which will create strong foundations for the whole system to function at its best. These changes are driven by learning from the experiences of Covid-19, but more broadly by the need to ensure we have a public health system fully fit for the future. The factors which prevent poor health are shaped by many different parts of government, public services and the broader health system. So rather than containing health improvement expertise within a single organisation, driving change in the future will mean we need many different organisations to have the capability and responsibility for improving health and preventing ill health.
- (c) In January, the Department of Health and Social Care and the Ministry of Justice published Reforming the Mental Health Act, a White Paper which responds to the Independent Review of the Act, chaired by Professor Sir Simon Wessely in 2018. This forms our plan to modernise mental health legislation. There is a clear case for modernisation and change. The White Paper sets out our proposals for a substantive programme of legislative reform, taking forward the government's commitment to legislate to give people greater control over their treatment, and ensure they are treated with the dignity and respect they deserve. It also takes forward our commitment to

improve how people with a learning disability and autistic people are treated in law and reduce the reliance on specialist inpatient services for these groups. We want everyone to have the opportunity to live a full and rewarding life in their communities and an end to perpetuated detentions without appropriate therapeutic inputs.

- 4.5 These reforms are not included in our legislative proposals but are part of a wider Departmental strategy.
- 4.6 On current timeframes, and subject to Parliamentary business and successful passage, our plan is that these proposals for health and care reform will start to be implemented in 2022. We will continue to engage with stakeholders across the health and care systems, our Arm's Length Bodies and the Devolved Administrations on the detail of these proposals as they progress. We will also continue to work across government to ensure that the right systems and processes are in place that work for all, recognising the interdependencies between health and other social determinants.

## 5. Annex A: Proposals for legislation

### Working together and supporting integration proposals

- 5.1 These proposals are about enabling different parts of the health and care system to work together effectively, in a way that will improve outcomes and address inequalities. The social care measures reflecting this theme are included as part of our additional proposals.

Working together and supporting integration proposals:

1. Establishing Integrated Care Systems
2. Duty to Collaborate
3. Triple Aim
4. Power over Foundation Trusts Capital Spend Limits
5. Joint committees
6. Collaborative Commissioning
7. Joint Appointments
8. Data Sharing
9. Patient Choice

### Establishing Integrated Care Systems (ICSs) in law

- 5.2 Integrated Care Systems (ICSs) have become an increasingly familiar part of the health and care landscape in recent years. Many of the pioneer ICSs have been highly successful in bringing partners together to improve outcomes for the public, often supporting and supplementing arrangements at place level.
- 5.3 Existing ICS arrangements are based on voluntary arrangements, rather than legislative provision, and are therefore dependent on goodwill and mutual co-operation. There are also legislative constraints on the ability of organisations within an ICS to make decisions jointly. While several systems have found ways to establish effective governance models, there are some obstacles and limitations in the current legal framework which inhibit this. For example, there is no legal basis



at present for Clinical Commissioning Groups (CCGs), NHS trusts and Foundation Trusts (FTs) to form a joint committee to which functions may be delegated, with the power to make decisions on behalf of the organisations within the ICS.

- 5.4 In order for ICSs 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.
- 5.5 The legislative provisions that we propose for Integrated Care Systems reflect NHS England's recommendations for change following their recent engagement on ICSs, and are designed to provide a small set of consistent requirements for each system that the partners who make up that system can then supplement with further arrangements and agreements that suit them. The role of ICSs in supporting integration both within the NHS and between the NHS and its partners in local authorities along with further detail on the purpose and governance of Integrated Care Systems is set out at Annex B. In this section we set out the core functions of the ICS along with a number of other provisions designed to support integration across the health and care system.
- 5.6 We are proposing to establish statutory ICSs, made up of an ICS NHS Body and an ICS Health and Care Partnership (together referred to as the ICS), to strengthen the decision-making authority of the system leadership and to embed accountability for system performance into the NHS accountability structure. This dual structure recognises that there are two forms of integration which will be underpinned by the legislation: the integration within the NHS to remove some of the cumbersome barriers to collaboration and to make working together across the NHS an organising principle; and the integration between the NHS and others, principally local authorities, to deliver improved outcomes to health and wellbeing for local people.
- 5.7 The ICS NHS Body will be responsible for:
- Developing a plan to meet the health needs of the population within their defined geography;
  - Developing a capital plan for the NHS providers within their health geography;
  - Securing the provision of health services to meet the needs of the system population.
- 5.8 The ICS NHS Body will model merge some of the functions currently being fulfilled by non-statutory STPs/ICSs with the functions of a CCG. We aim to bring the allocative functions of CCGs into the ICS NHS body so that they can sit alongside

the strategic planning function that we would like the ICS to undertake. This will enhance accountability and allow the members of the ICS to develop integrated and innovative approaches to deliver strategic objectives. Our proposals would also, in line with the approach set out by NHS England, allow for the ICS NHS Body to delegate significantly to place level and to provider collaboratives. To support our ambition for ICSs to also address broader health outcomes - including through improving population health and tackling inequalities - each ICS will also be required to establish an ICS Health and Care Partnership, bringing together health, social care, public health (and potentially representatives from the wider public space where appropriate, such as social care providers or housing providers). This body will be responsible for developing a plan that addresses the wider health, public health, and social care needs of the system – the ICS NHS Body and Local Authorities will have to have regard to that plan when making decisions.

- 5.9 In practice, we recognise that ICSs will have to develop effective and legitimate decision-making processes, and we are giving ICS NHS bodies and ICS Health and Care Partnership the flexibility to develop processes and structures which work most effectively for them. We also know that we need to support staff during organisational change by minimising uncertainty and limiting employment changes. We are therefore seeking to provide stability of employment and will work with NHSE and staff representatives to manage this process.
- 5.10 A key responsibility of the ICS will be working in partnership with other local bodies, both within the health and social care system, and more widely. In order to facilitate this, we will make it easier for organisations to work closely together, for example, through our new proposals for joint committees (see below) and existing collaborative commissioning arrangements (such as s.75 of the NHS Act 2006). This joint approach to working will also be supported by the “triple aim duty” (see the proposal below).
- 5.11 The ICS will also have to work closely with local Health and Wellbeing Boards (HWB) as they have the experience as ‘place-based’ planners, and the ICS NHS Body will be required to have regard to the Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies that are being produced at HWB level (and vice-versa). ICSs will also want to think about how they can align their allocation functions with place, for example through joint committees, though we are leaving this to local determination. NHS Trusts and Foundation Trusts (FTs) will remain separate statutory bodies with their functions and duties broadly as they are in the current legislation.
- 5.12 The creation of statutory ICS NHS Bodies will also allow NHS England to have an explicit power to set a financial allocation or other financial objectives at a system

level. There will be a duty placed on the ICS NHS Body to meet the system financial objectives which require financial balance to be delivered. NHS providers within the ICS will retain their current organisational financial statutory duties. The ICS NHS Body will not have the power to direct providers, and providers' relationships with the Care Quality Commission will remain unchanged. However, these arrangements will be supplemented by a new duty to compel providers to have regard to the system financial objectives so both providers and ICS NHS Bodies are mutually invested in achieving financial control at system level.

- 5.13 We know there has been excellent progress in some areas in making a reality of integrated care. We also know that this has sometimes been in spite of the systems we ask people to work within, and that it is far from universally true that integration is proceeding in step with the needs and lives of the people we serve. We have therefore – with the help of NHS England's work following the Long Term Plan – identified several further changes to reinforce or enable integration. Details of the NHS's proposals, which we have bolstered with an additional duty to collaborate, are set out below.

## **Duty to collaborate**

- 5.14 Alongside the creation of statutory ICSs, we intend to introduce a new duty to promote collaboration across the healthcare, public health and social care system. Many existing duties on health and care organisations emphasise the role of the individual organisation and its own interests. We want to rebalance these duties to reflect the need for all health and care organisations to work collaboratively. When collaboration works well it leads to better outcomes for people, for example a successful early intervention can lead to people living independently and in their own homes for longer.
- 5.15 This proposal will place a duty to collaborate on NHS organisations (both ICSs and providers) and local authorities. This policy also provides the Secretary of State for Health and Social Care with the ability to issue guidance as to what delivery of this duty means in practice, in recognition of the fact that collaboration may look very different across different kinds of services.
- 5.16 We intend this collaboration proposal to replace two existing duties to cooperate in legislation to support our wider ICS policy, where we expect local authorities and NHS bodies to work together under one system umbrella.

## **Triple Aim**

- 5.17 To further support integration, we propose to implement NHS England's recommendation for a shared duty that requires NHS organisations that plan

services across a system (ICSs) and nationally (NHS England), and NHS providers of care (NHS Trusts and FTs) to have regard to the 'Triple Aim' of better health and wellbeing for everyone, better quality of health services for all individuals, and sustainable use of NHS resources.

- 5.18 This will support NHS bodies to continue a culture of working together in the best interest of not only their immediate service users and organisations, but of the wider population, and for the ICS as a whole, working together strategically and through its 'place'- based constituents. We hope that the Triple Aim will help align NHS bodies around a common set of objectives, thus supporting the shift towards integrated systems which have strong engagement with their communities.

### **Reserve power over Foundation Trusts Capital Spend Limit**

- 5.19 We are also planning to implement NHS England's recommendation for a reserve power to set a capital spending limit on Foundation Trusts, which will support the third aim of the Triple Aim duty, in relation to sustainable use of NHS resources.
- 5.20 Unlike NHS Trusts, which are set annual capital expenditure limits by NHS Improvement, NHS Foundation Trusts (FTs) currently have additional freedoms to borrow from commercial lenders and spend surpluses on capital projects (e.g. new buildings, equipment or IT). However, capital expenditure by FTs still counts towards DHSC's overall Capital Delegated Expenditure Limit (CDEL).
- 5.21 In recent years, given the restraint on capital expenditure and a growing maintenance backlog, the Department of Health and Social Care has had to restrict capital expenditure by Trusts and temporarily delay capital projects to ensure that it does not breach its CDEL limit. A small number of FTs have previously indicated that they could push ahead with their individual schemes and use their own capital, without full consideration of the overall impact on the ICS and on CDEL as a whole. This could mean that at ICS or national level we may have to pause other schemes which may be strategically more beneficial or clinically required. Dialogue is the first line of defence and remediation locally and nationally, but a targeted reserve power is required as a last resort to protect the system and ensure the most sustainable use of NHS resources.
- 5.22 As we embed a new capital regime where Integrated Care Systems (ICS) are allocated a system-wide capital limit, and have duties placed upon them to create a capital plan, we are seeking powers in the Bill to be able to set legally-binding Capital Departmental Expenditure Limits (CDEL) for individual, named Foundation Trusts (FTs), where they are not working effectively to prioritise capital expenditure within their ICS, and risk breaching either system or national CDEL limits.

- 5.23 This is not a general power to direct all FTs on capital spending and is not intended to erode FT autonomy, but it is designed to be used in targeted ways to support the work of ICSs.

## **Joint Committees**

- 5.24 As NHS England set out in their engagement document, legislation does not currently allow NHS providers (NHS trusts and foundation trusts) and CCGs (which will become part of ICSs) to take joint decisions, either through a joint committee or committees-in-common, or for local authorities and other providers of NHS care to be involved in such partnership arrangements. Furthermore, Foundation Trust boards and individual directors have a duty to act with a view to promoting the success of their organisation. This creates an unhelpful barrier to joint working, and 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.
- 5.25 Our ICS NHS body provisions go most of the way to increasing the ease with which providers and commissioners could establish joint working arrangements and support the effective implementation of integrated care. We consider, nonetheless, that NHS England's recommendation to allow ICSs and NHS providers to create joint committees would be a useful addition, removing unnecessary barriers to joined-up decision making.
- 5.26 We are therefore proposing to create provisions relating to the formation and governance of these joint committees and the decisions that could be appropriately delegated to them; and separately, allowing NHS providers to form their own joint committees. Both types of joint committees could include representation from other bodies such as primary care networks, GP practices, community health providers, local authorities or the voluntary sector.

## **Collaborative Commissioning**

- 5.27 We want to support the health and care system to work collaboratively and flexibly across different footprints. Many local areas have been exploring ways of working more collaboratively and are seeking to align decisions and pool budgets between CCGs and NHS England, across CCGs, and between CCGs and local authorities (LAs).
- 5.28 Existing NHS legislative mechanisms make it difficult to do this, forcing local systems 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 decision-making processes. We intend to

implement NHS England's recommendation to change the underpinning NHS legislation to remove these barriers and streamline and strengthen the governance for this type of decision-making.

5.29 These proposals will:

- Give NHS England the ability to joint commission its direct commissioning functions with more than one ICS Board, allowing services to be arranged for their combined populations.
- Allow ICSs to enter into collaborative arrangements for the exercise of functions that are delegated to them, enabling a "double-delegation".
- Allow groups of ICSs to use joint and lead commissioner arrangements to make decisions and pool funds across all their functions (and not just commissioning functions).
- Enable a greater range of delegation options for section 7A public health services, including the ability for onward delegation of the function into collaborative arrangements, such as a section 75 partnership arrangement; and
- Enable NHS England to delegate or transfer the commissioning of certain specialised services to ICSs singly or jointly, or for NHS England to jointly commission these services with ICSs if these functions are considered suitable for delegation or joint commissioning subject to certain safeguards. 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.

## **Joint Appointments**

5.30 To support closer working between actors in the health and care system, greater clarity is needed to enable joint appointments across different organisations.

5.31 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.

5.32 In line with NHS England's recommendation, we are proposing to introduce a specific power to issue guidance on joint appointments between NHS Bodies; NHS Bodies and local authorities; and NHS Bodies and Combined Authorities. This will aid the development and delivery of integrated care and will ensure that there is a clear set of criteria for organisations to consider when making joint appointments.

5.33 NHS England will need to keep the guidance under review, and if substantial changes to it are considered, they will need to consult appropriate organisations before the revision is published.

## Data Sharing

5.34 Building on the successful data sharing in response to Covid-19, we want to ensure that health and care organisations use data, when they can do so and with appropriate safeguards, for the benefit of individuals and the wider health and social care system. The forthcoming Data Strategy for Health and Care will set out a range of proposals to address structural, cultural/behavioural and legislative barriers to data sharing and a more flexible legislative framework to improve data access and interoperability, including enabling the safe sharing of data in support of individual care, population health and the effective functioning of the system. As part of this work, we are exploring where achieving these objectives may require primary legislation. This includes proposals to:

- require health and adult social care organisations to share anonymised information that they hold where such sharing would benefit the health and social care system.
- introduce powers for the Secretary of State for Health and Social Care to require data from all registered adult social care providers about all services they provide, whether funded by local authorities or privately by individuals (discussed further in the Adult Social Care proposals); and require data from private providers of health care.
- make changes to NHS Digital’s legal framework to introduce a duty on NHS Digital to have regard to the benefit to the health and social care system of sharing data that it holds when exercising its functions; and clarify the purposes for which it can use data.
- introduce a power for the Secretary of State for Health and Social Care to mandate standards for how data is collected and stored, so that data flows through the system in a usable way, and that when it is accessed/provided (for whatever purpose), it is in a standard form, both readable by, and consistently meaningful to the user/recipient.

The measures in this Bill will help NHS organisations join up, to provide better care for the public and to plan services. None of the measures here will erode the protection of personal information.

## Patient Choice

- 5.35 Integrated services provide an opportunity to offer joined up care to all and provide clear information on the choices people have in how and where their care is delivered. A patient's right to choose where and who will provide their health and care needs will be preserved and strengthened in the new system arrangements.
- 5.36 The NHS's Long-Term Plan (LTP) makes specific proposals to strengthen patient choice and control. The LTP states that the ability of patients to choose where they have their treatment remains a powerful tool for delivering improved waiting times and patient experiences of care. The LTP also states that the NHS will continue to provide patients with a wide choice of options for quick elective care, including making use of available Independent Sector capacity. The protections and rights in relation to patient choice and the Any Qualified Provider (AQP) requirements are fundamentally set out in the current legislation.
- 5.37 As part of the wider package of changes to the arrangement of healthcare services, we propose to repeal section 75 of the Health and Social Care Act 2012 Act including the Procurement, Patient Choice and Competition Regulations 2013 and replace the powers in primary legislation under which they are made with a new provider selection regime. Under the new model, bodies that arrange NHS Services as the decision-making bodies will be required to protect, promote and facilitate patient choice with respect to services or treatment. We also want to make clearer the rules, circumstances and processes around the operation of Any Qualified Provider (AQP).
- 5.38 We will take forward the NHS's recommended approach by retaining existing patient choice rights and protections and bolstering the process for AQP arrangements. In addition, ICSs can be powerful drivers of patient centred approaches that provide greater choice and control to patients by transforming services around the specific needs of their populations.
- 5.39 We will also work closely with the NHS to reduce the health inequalities currently experienced in the area of choice, by helping to increase clarity and awareness of patient choice rights within systems and of the range of choices available.

## Reducing bureaucracy proposals

- 5.40 These proposals focus on stripping out needless bureaucracy, turning effective innovations and bureaucracy busting into meaningful improvements for everyone, learning from the innovations during Covid-19.

Reducing Bureaucracy proposals:



1. Competition
2. Arranging healthcare services
3. National Tariff
4. New Trusts
5. Removing Local Education Training Boards (LETBs)

5.41 The Department's recent [Busting Bureaucracy](#) exercise showed how bureaucracy can act as a barrier to the frontline when delivering care. We want to remove those barriers and use our legislation to give people in the system the flexibility to work together to improve services for everyone. We also want to remove parts of the legislation which no longer reflect the current ways of working and have necessitated complex and often bureaucratic workarounds, and made it difficult for the system to adapt over time as needed. The social care measures reflecting this theme are included as part of our additional proposals set out below.

## Competition

5.42 Whilst competition can drive service improvement, it has in some cases hindered integration between providers. Currently, the Competition and Markets Authority (CMA) have specific powers to review mergers involving Foundation Trusts (FT). It has become clear that the CMA is not the right body to review NHS mergers. In line with NHS England's recommendations, we intend to remove these powers and allow NHS England, as overseer of the system, to ensure that decisions can always be made in the best interests of patients. The CMA's jurisdiction over mergers is UK-wide, so we are working with the devolved administrations to ensure there would be no unintended consequences of these proposals.

5.43 Building on the experience of the last few years, we now want to take forward proposals to legislate to clarify the central role of collaboration in driving performance and quality in the system, rather than competition. The proposals are to:

- Remove the CMA function to review mergers involving NHS foundation trusts. The CMA's jurisdiction in relation to transactions involving non-NHS bodies (e.g. between an NHS Trust/FT and private enterprise) and other health matters (e.g. drug pricing) would be unchanged.
- Remove NHS Improvement's specific competition functions and its general duty to prevent anti-competitive behaviour.

- Remove the need for NHS England to refer contested licence conditions or National Tariff provisions to the CMA.

5.44 Alongside the role of competition in driving service improvement, it is also right that (as the newly merged body) NHS England's main role is on supporting improvements in health outcomes, the quality of care and use of NHS resources.

## **Arranging healthcare services**

5.45 The NHS has sent us a clear message that the current regime for arranging healthcare services is not working. It is confusing, overly bureaucratic and does not support the integration and efficient arrangement of services in the best interest of patients.

5.46 In line with the requests made by NHS England, which garnered strong support from the wider system, we will use legislation to remove much of the transactional bureaucracy that has made sensible decision-making and collaboration in the system harder. We will reform the approach to arranging healthcare services and create a bespoke regime that will give commissioners more discretion over when to use procurement processes to arrange services than at present, with proportionate checks and balances. Where competitive processes can add value they should continue, but that will be a decision that the NHS will be able to make for itself.

5.47 The reforms within these legislative proposals will remove the current procurement rules which apply for NHS and public health commissioners when arranging healthcare services. They will do this by creating the powers to remove the commissioning of these services from the scope of the Public Contracts Regulations 2015, as well as repealing Section 75 of the Health and Social Care Act 2012 and the Procurement, Patient Choice and Competition Regulations 2013.

5.48 The powers within the Bill are intended to enable us to develop a new provider selection regime which will provide a framework for NHS bodies and local authorities to follow when deciding who should provide healthcare services. The provider selection regime will be informed by NHS England's public consultation , and aims to enable collaboration and collective decision-making, recognising that competition is not the only way of driving service improvement, reduce bureaucracy on commissioners and providers alike, and eliminate the need for competitive tendering where it adds limited or no value. Commissioners will be under duties to act in the best interests of patients, taxpayers, and the local population when making decisions about arranging healthcare services.

- 5.49 We anticipate that there will continue to be an important role for voluntary and independent sector providers, but we want to ensure that, where there is no value in running a competitive procurement process, services can be arranged with the most appropriate provider. The NHS will continue to be free at the point of care and our proposals seek to ensure that where a service can only be provided by an NHS provider e.g. A&E provision, that this process is as streamlined as possible.
- 5.50 These reforms will only apply to the arrangement of healthcare services – including public health services whether commissioned solely by a local authority or jointly by the local authority and NHS as part of a S75 agreement. The procurement of non-clinical services, such as professional services or clinical consumables, will remain subject to Cabinet Office public procurement rules.

## **National Tariff**

- 5.51 The legislation for the National Tariff allows a substantial degree of flexibility, in what is a complex area – but it was in part designed to further implement a system of ‘payment by results’ or payment by activity, as part of the wider 2012 Act reforms, and in some respects its provisions may not always best facilitate new payment approaches to support collaboration or support the use of digital tech and services in the provision of care. As we move towards a system of ICSs focused on population health, we want to ensure that the payment system supports that direction of travel.
- 5.52 The set of proposals relating to the National Tariff are intended to implement NHS England’s recommendations and 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. Experiences during the pandemic have also demonstrated the positive impact that financial frameworks can have on facilitating joint working.
- 5.53 We will take forward NHS England’s proposals on the National Tariff, by amending the legislation to enable the National Tariff to support the right financial framework for integration whilst maintaining the financial rigour and benchmarking that tariff offers. This includes:
- Where NHS England specifies a service in the National Tariff, then the national price set for that service may be either a fixed amount or a price described as a formula.
  - NHS England could amend one or more provisions of the National Tariff during the period which it has effect, with appropriate safeguards.

- Remove the requirement for providers to apply to NHS Improvement for local modifications to tariff prices.
- NHS England should be able to include provisions in the National Tariff on pricing of NHS public health services where exercising public health functions delegated by the Secretary of State.

## **New Trusts**

- 5.54 We are not seeking to significantly alter the provider landscape; however, NHS England's recommendations to government included a provision to allow the creation of new trusts for the purposes of providing integrated care. We agree that there may be merit in creating a new trust to provide integrated care, and there may also be other circumstances when the Secretary of State may want to create a new trust. Consequently, we intend to allow the creation of new NHS trusts with the overriding objective of ensuring the health system is structured to deliver the best outcomes for whole population health and respond to emerging priorities. This is in line with our overarching aim to ensure the system is flexible and adaptable into the future, and wherever possible avoids the need for complex workarounds to deliver system priorities.
- 5.55 We are therefore bringing forward measures that will enable ICSs to apply to the Secretary of State to create a new trust. Any new trust will be subject to appropriate engagement and consultation. This process will be set out in guidance.

## **Removing Local Education Training Boards (LETBs)**

- 5.56 The collaborative working between Health Education England (HEE), NHS England and NHS Improvement and the Department on the development of the [NHS People Plan](#) has shown the need for a flexible and future-proofed regional workforce operating model.
- 5.57 In light of this work, we have reviewed the role of Local Education and Training Boards. These were originally established in 2012 as statutory sub-committees of HEE to perform HEE's functions at local and regional level by ensuring effective regional planning systems for the planning and delivery of education and training. In addition, LETBs had a direct role in commissioning the education and training required at local level, a role which has diminished following the 2017 education funding reforms. However, LETB functions are restricted by legislation which has limited their scope to adapt and interact with the regional directorates of NHS England and Improvement and the newly established non-statutory Regional

Workforce and People Boards (which now provide an architecture consistently across England for oversight of Workforce, Education and Training).

- 5.58 We are proposing to amend the Care Act 2014 (which sets out the functions and constitution of HEE and LETBs) to remove LETBs from statute. We believe removing LETBs from statute with their functions continuing to be undertaken by HEE (and reporting to the HEE Board) will provide HEE with the flexibility to adapt its regional operating model over time. Accompanied with our proposal for the Secretary of State for Health and Social Care to take a statutory duty to publish a document outlining the workforce planning and supply system at national, regional and local level, this measure will provide clarity over responsibilities.
- 5.59 While LETBs operate only in England, we will work with devolved administrations should this proposal have any UK-wide impact.
- 5.60 This proposal was not directly recommended by NHS England, but it flows as a consequence of the changes being recommended by NHS England to encourage more system working, and fits with our plans to ensure the legislative framework is not overly rigid or restrictive, and can adapt over time as needed.

## **Ensuring accountability and enhancing public confidence proposals**

- 5.61 These proposals focus on enhancing public confidence by ensuring that we have the right framework 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.

### Ensuring accountability and enhancing public confidence proposals

1. Merging NHS England, Monitor and the NHS Trust Development Authority and Secretary of State powers of direction
2. The NHS Mandate
3. Reconfigurations intervention power
4. Arm's Length Bodies (ALB) Transfer of Functions
5. Removing Special Health Authorities Time Limits
6. Workforce Accountability

## **Merging NHS England, Monitor and NHS Trust Development Authority and Secretary of State powers of direction**

- 5.62 In their recommendations to Government, NHS England recommended that NHS England and NHS Improvement should be permitted to merge fully, as requested by both their boards and strongly supported in the engagement responses.
- 5.63 As NHS Improvement currently consists of the NHS Trust Development Authority (NHS TDA) and Monitor, we are proposing to formally transfer their functions to NHS England and abolish Monitor and the NHS TDA.
- 5.64 Over the last two years, we have seen NHS England and NHS Improvement come together to work effectively as a single organisation. We have seen clear benefits from them working in practice as one organisation providing national leadership: speaking with one voice, setting clearer and more consistent expectations for providers, commissioners and local health systems; removing unnecessary duplication; using collective resources more efficiently and effectively to support local health systems and ultimately making better use of public money.
- 5.65 Despite the success of NHS England and NHS Improvement's joint working programme, there are limits to how far they can fully collaborate under the current legislation. For example, both organisations have separately been assigned some distinctive and non-shareable functions in legislation – they are currently required to have separate Boards, Chairs, CEOs and non-executive directors and still consist of three separate employers. Despite the efforts of both organisations to find practical arrangements and 'work-arounds', these restrictions and governance arrangements prevent the organisations from fully operating as one single organisation.
- 5.66 The public largely see the NHS as single organization and as local health systems work more closely together, the same needs to happen at a national level.
- 5.67 By bringing forward this proposal to formally bring NHS England and NHS Improvement together, we will remove these remaining bureaucratic and legislative barriers, enabling the organisation to legally come together as one to provide unified national leadership for the NHS.
- 5.68 As a newly public merged body, NHS England will, of course, remain answerable to the Secretary of State for Health and Social Care and Parliament for all aspects of NHS performance, finance and care transformation. However, the NHS England of 2022 will combine NHS England itself with Monitor and the NHS Trust

Development Authority, each of which currently have different accountabilities. Recognising this evolution, we are bringing forward a complementary proposal to ensure the Secretary of State has appropriate intervention powers with respect to NHS England. This will maintain clinical and day to day operational independence for the NHS but will support accountability by allowing the Secretary of State for Health and Social Care to formally direct NHS England in relation to relevant functions. This will support system accountability and agility, and also enable the Government to support NHS England to align its work effectively with wider priorities for health and social care. This will serve, in turn, to reinforce the accountability of the Secretary of State and Government for the NHS and the wider health and care system.

- 5.69 The public and patients need to know that when issues arise, and when people need answers to their concerns, there are systems in place to address the issues at the appropriate level. That is likely to almost always be done within systems rather than at a national level. However, there will be occasions when it will be necessary for national leadership and for NHS England to set direction. Equally, there will be occasions when it is appropriate for ministers to take more oversight in relation to NHS England, and these proposed powers would structure such interventions and ensure Ministers are accountable for them.
- 5.70 It will also support the Secretary of State to set clear direction in a more agile way, and to do so formally alongside the strong and effective informal arrangements for working together that have evolved between the Department and NHS England in recent years.
- 5.71 These powers will not allow Secretary of State to direct local NHS organisations directly nor will they allow the Secretary of State to intervene in individual clinical decisions. They will also not undermine the established NICE process and guidance for treatments and medicines.

## **The NHS Mandate**

- 5.72 Each year the Government publishes the NHS mandate, a document which sets out the objectives which NHS England should seek to achieve. The NHS mandate is intended to set strategic direction for the NHS by setting out the top priorities that the Government expects NHS England to focus on delivering. These objectives are carried through to NHS England's planning guidance.
- 5.73 When NHS England, Monitor and the NHS Trust Development Authority are legally merged, the current statutory mandate to NHS England will cover the whole of the combined organisation.

- 5.74 At present, the process for setting, publishing and replacing the mandate is linked to the financial cycle and takes place annually. Before the start of each financial year, the Secretary of State for Health and Social Care must publish and lay before Parliament the NHS mandate. However, this annual cycle has become problematic as it does not align with timescales for other strategic decisions that should influence and align with the mandate's content. For example, by the time the mandate is published alongside the new financial year, the NHS has completed its annual planning round and local organisations have signed off plans for the coming year.
- 5.75 To allow the mandate to set direction over a longer term and in a more strategic way than currently permitted by the annual cycle, we are proposing to replace the current legislative requirement to have a new mandate each year with a new requirement to always have a mandate in place. It will also provide the flexibility for the mandate to be replaced to respond to changing strategic needs, emerging evidence on deliverability or appropriateness of objectives, or external events, rather than having to wait until the next annual opportunity.
- 5.76 This proposal will remove the duty to set NHS England's capital and revenue resource limits in the mandate itself. Instead, these limits will continue to be set within the annual financial directions that are routinely published, and which will, in future, also be laid in Parliament. The direction set in the mandate will continue to be closely aligned to the capital and resource spending limits set through financial directions. The Secretary of State will retain their duty to consult NHS England before setting a mandate.
- 5.77 Additional consequential changes will also be made to the current legal provisions on integration (the Better Care Fund) which currently rely on the NHS mandate. These provisions will be recreated as a standalone power so that they will continue to meet the policy intention for the Better Care Fund even where mandates are not replaced annually.
- 5.78 This proposal will not impact on Parliament's ability to scrutinise the mandate – each new mandate will continue to be laid in Parliament by the Secretary of State and will be published. NHS mandate requirements will also continue to be underpinned by negative resolution regulations, providing further opportunity for Parliament to engage with the content of the mandate. Furthermore, the existing duty for the Secretary of State to consult NHS England, Healthwatch England, and any other persons they consider appropriate before setting objectives in a mandate, will also remain in place. Healthwatch England's involvement ensures that all NHS mandates are informed by the needs of patients and the public.



## Reconfigurations intervention power

- 5.79 Reconfigurations involve changing the way NHS services are delivered to patients, such as the closure of several stroke units being replaced with a single centralised hyper acute unit.
- 5.80 Most service changes happen locally by consent – planned reconfigurations are developed at local or regional levels by commissioners. The current system for reconfigurations works well for most service changes, and so this will remain in place for the majority of day-to-day transactions.
- 5.81 Where it does not work well, however, is in cases which are a significant cause for public concern or are particularly complex. Inevitably some can be more controversial and can lead to difficult – even intractable – debate and processes that stretch on for years.
- 5.82 The Secretary of State is currently only able to intervene in such cases upon receiving a local authority referral and may commission the Independent Reconfiguration Panel to provide recommendations. After receiving these, the Secretary of State will communicate his final decision. Whilst this can help with difficult cases, referrals can often come very late in the process. This can lead to difficult debates and lengthy processes, meaning a long and arduous journey to a decision being made and local areas and their democratic representatives are left in limbo. This leaves ministers in the position of having to account for service changes in Parliament without having been meaningfully engaged on them themselves. In the context of Covid-19, the situation on reconfigurations (especially temporary ones) is integral to understanding both system resilience and the strengths and weaknesses of recovery plans.
- 5.83 We are therefore proposing to broaden the scope for potential ministerial intervention in reconfigurations, creating a clear line of accountability, by allowing the Secretary of State to intervene at any point of the reconfiguration process. The Secretary of State will be required to seek appropriate advice in advance of their decision, including in relation to value for money, and subsequently publish it in a transparent manner.
- 5.84 To support this intervention power, we will introduce a new process for reconfiguration that will enable the Secretary of State to intervene earlier and enable speedier local decision-making. We will issue statutory guidance on how this process will work as well as removing the current local authority referral process to avoid creating any conflicts of interest. We will publish further details of proposed arrangements in due course. This would mean that we expect the Independent Reconfiguration Panel to be replaced by new arrangements. Since its establishment in 2003, the Independent Reconfiguration Panel has provided

advice to the Secretary of State on over 80 cases and we will learn from the work of the IRP as we develop processes that build on lessons and principles for achieving successful service change.

- 5.85 We do not anticipate this power being used with great frequency but where there are issues that Ministers have concluded need to be pressed to a resolution, this will provide a means of doing so.

## **Arm's Length Bodies (ALB) Transfer of Functions Power**

- 5.86 Looking beyond just NHS England, to the wider national landscape, we have seen the Department's Arm's Length Bodies, with all their differing functions and operations, respond rapidly to the Covid-19 pandemic and demonstrating immense flexibility. From the outset, core activities were streamlined whilst new Covid-19 related work programs were implemented. We have seen our ALBs working more closely together in collaborative ways in order to support and improve people's health and care.
- 5.87 It is important that when needed, we can support our ALBs to work flexibly, make it easier for them to respond to future challenges, and provide clarity about who is responsible and accountable for various functions. Therefore, we are proposing to create a power in primary legislation for the Secretary of State for Health and Social Care to transfer functions to and from specified ALBs. This mechanism will allow us to review where functions are best delivered in order to support a more flexible, adaptive and responsive system. In cases where an ALB becomes redundant as a result of transfer of its functions, this power will also include the ability to abolish that ALB. The power to transfer functions and the power to abolish an ALB will be only be exercisable via a Statutory Instrument (SI), following formal consultation. Devolved administrations will also be consulted from the outset so that provision can be made for their approval of any transfer of functions that are operative within their nations.
- 5.88 In the responses to NHS England's engagement exercise, stakeholders sought further detail and clarity about how the power could be used. 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 (as we have seen between NHS England and NHS Improvement, for example).
- 5.89 There is no immediate plan to use this power. Use of this power will be subject to a full, open and transparent process throughout. Before it can be used, a formal consultation will be required. The Secretary of State will also need to consider any

recommendations made by Parliamentary Committees, and both Houses of Parliament would need to approve the proposal. This process will ensure that the ALBs, the wider health and care system, and Parliament will have the opportunity to scrutinise any plans for its use, and to ensure that any movement of functions is right for the health and care system and the public.

## **Special Health Authorities Time Limits**

- 5.90 We greatly value our Special Health Authorities (SpHAs) and the work that they do. There are currently five SpHAs, each with their own distinct and important roles. These are the NHS Business Services Authority (NHSBSA), the NHS Trust Development Authority (TDA), NHS Blood and Transplant (NHSBT), NHS Resolution (NHSR) and the NHS Counter Fraud Authority (NHSCFA).
- 5.91 Currently, existing legislation sets an automatic expiry date on SpHAs set up after 2012, which requires us to formally extend their existence every three years. This is a time consuming and bureaucratic process that creates unnecessary administration costs for the SpHAs and the department.
- 5.92 This proposal will remove the three-year time limit on all SpHAs. Not only is this time limit unnecessary as the functions of the SpHAs are enduring, it is also inconsistent as the time limits only currently impact one SpHA, the Counter Fraud Authority (CFA); and any future SpHAs that come into being would also be subject to the time limit legislation. By removing this time limit, we are ensuring all SpHAs are treated equally in legislation and removing the bureaucratic, time consuming and duplicative process.

## **Workforce Accountability**

- 5.93 The Department is proposing to create a duty for the Secretary of State for Health and Social Care to publish a document, once every five years, which sets out roles and responsibilities for workforce planning and supply in England. This document would:
- cover the NHS including primary, secondary, community care and where sections of the workforce are shared between health and social care e.g. registered nurses, and health and public health e.g. doctors and other regulated healthcare professions.
  - describe the workforce planning and supply system including the roles of DHSC and its Arm's Length Bodies, NHS bodies and others and how they work together.
  - not give any bodies additional functions to those they already have in statute,

- be co-produced with (at a minimum) Health Education England and NHS England.

5.94 The purpose of this document is to set out in one document the current roles and responsibilities in order to provide greater transparency.

## **Additional proposals**

5.95 The remaining proposals are designed to support social care, public health and safety and quality.

### Social care

1. Data
2. Assurance
3. Direct payments to providers
4. Discharge to assess
5. A standalone power for the Better Care Fund

### Public health

6. Public Health power of direction
7. Obesity
8. Fluoridation

### Safety and Quality

9. Health Services Safety Investigations Body (HSSIB)
10. Professional Regulation
11. Medical Examiners
12. Medicines and Healthcare products Regulatory Agency (MHRA) new national (UK-wide) medicines registries
13. Hospital food standards
14. Reciprocal healthcare agreements with Rest of World countries

## **Social Care**

- 5.96 We are proposing a number of specific and targeted social care changes which address the key themes of the Bill. Our proposed legislative measures encourage joined up care for everyone by ensuring local government and social care stakeholders are at the heart of our ICS proposals, and by amending the legal framework to enable person-centred approaches to hospital discharge. A new power for the Secretary of State to make payments directly to adult social care providers, will remove a bureaucratic barrier to delivering support to the sector in exceptional circumstances like those we have seen in the last year. Finally, we want to increase accountability in the delivery of social care through an enhanced assurance framework examining the performance of local authorities, and a new power to collect data from providers.
- 5.97 These measures embed improvements that have been made to the system as it has adapted to address needs arising from Covid 19. They will grant us a greater ability to respond flexibly to the needs of the sector while adapting and developing existing practice in a way that does not place undue burden on local authorities or social care providers. The Bill will also serve as a platform for detailed policy design in collaboration with stakeholders as we move forward on wider reforms for the sector.
- 5.98 The legislative measures in the Bill are just one element of a wider programme of positive reform for the adult social care sector. We remain committed to sustainable improvement of the adult social care system and will bring forward wider social care reform, with proposals to be published this year.

## **Integrated Care Systems and Adult Social Care (ASC)**

- 5.99 ICS legislation will complement and reinvigorate place-based structures for integration between the NHS and Social Care, such as Health and Well-Being Boards, the Better Care Fund and pooled budget arrangements. The ICS Health and Care Partnership will be a springboard for bringing together health, local authorities and partners, to address the health, social care, and public health needs at a system level, and to support closer integration and collaborative working between health and social care. We will support this by published guidance that will offer support for how ICS Health and Care Partnerships can be used to align operating practices and culture with the legislative framework to ensure ICSs deliver for the ASC sector.
- 5.100 We will also create a more clearly defined role for Social Care within the structure of an Integrated Care System NHS Board. This will give ASC a greater voice in NHS planning and allocation.

- 5.101 We also recognise the importance of bringing together ICSs and Health and Wellbeing Boards (HWB) as complimentary bodies at system and place level. ICS NHS Bodies and Health and Care Partnerships will have formal duties to have regard to HWB plans, and we will continue to support and prioritise meaningful integration that makes patient and user journey's smoother.
- 5.102 Putting ICSs on a statutory basis will also act as a foundation for future work to shape ICSs as they develop, to ensure that they effectively promote integration between health and care at place level, as well as improving integration within the NHS. The active involvement of the sector in this work going forwards will be hugely important in ensuring that ICSs deliver for adult social care.

### **Improve the quality and availability of data across the Health and Social Care Sector**

- 5.103 We need to make changes to the data we collect and the frequency with which we collect it; not just for central government assurance and oversight, (further detail is provided on this below), but so that local authorities, providers and consumers can access the data they need, while minimising the burden on data providers. Building on improvements made by existing tools such as the capacity tracker implemented during the pandemic and an increased ability to gather data from social care providers (for both local authority and privately funded care), we will remedy gaps in available data to help us understand capacity and risk in the system. This will enable the Department to better understand the system to inform future policy developments and ultimately help facilitate the care of individuals across the care system. Unlike the NHS, adult social care is not one national system. Many bodies currently collect information but there is little standardisation in how data are collated, shared and used. Data should flow better to cover the whole sector, and this represents a first step towards development of a more integrated data system.
- 5.104 One such gap in our existing data from local authorities is around services provided to those who self-fund their care. By collecting data from social care providers on the services they offer we will be able to better understand this aspect of the system. Data on hours of care services provided and their cost per person, together with data on financial flows, will show how money flows to providers and workforce. With client level data, we can make links with health data and use it to improve our understanding of the lifetime cost of care. This will also support improved cooperation and joint decision-making between health and social care partners in delivering shared outcomes.
- 5.105 With more and better data, we can plan the future care of our population and will have the potential to generate significant health benefits such as increased independence, improved quality of care, higher patient satisfaction and more

efficient use of funding. Improved data on the sector workforce can also benefit recruitment, retention and equality policies.

- 5.106 We want high quality data, collected to agreed high standards and that meets the needs of all users. Through technology and data strategies, and through the Data Alliance Partnership, we are working to ensure the most efficient methods of data collection, improvement in the interoperability of systems will mean that data will be able to be collected through provider systems, reducing reporting burdens by extracting from existing data sets and sharing with multiple users. By maximising the use of technology and using data intelligently, we will support commissioning and delivery of high-quality services.

### **A new assurance framework for social care**

- 5.107 Demographic change has resulted in more people turning to social care and we expect this trend to continue for the foreseeable future. Local authorities are at the forefront of our response to this challenge, and we welcome their commitment to providing high quality outcomes as envisaged through the Care Act 2014, placing an emphasis on personalisation, choice and early intervention.
- 5.108 As social care affects a greater number of people at some point during their lives, accountability for services becomes increasingly important for both national and local government. It is therefore only reasonable for Government to want to ensure the ASC system is delivering the right kind of care, and the best outcomes, with the resources available. We also want to be able to readily identify best practice across the system, building on existing sector-led support and improvement programmes. To achieve this, we want to work with local authorities and the sector to enhance existing assurance frameworks that will support our drive to improve the outcomes and experience of people and their families in accessing high quality care and support, regardless of where they live. To support these goals, we propose to introduce through the Health and Care Bill, a new duty for the Care Quality Commission to assess local authorities' delivery of their adult social care duties. Linked to this new duty we also propose to introduce a power for the Secretary of State to intervene where, following assessment under the new CQC duty, it is considered that a local authority is failing to meet their duties. Any intervention by the Secretary of State would be proportionate to the issues identified and taken as a final step in exceptional circumstances when help and support options have been exhausted. Our plan is to secure these provisions in primary legislation at a high-level, prior to working with government partners and the sector on detailed system design and practice, providing a long-term basis of consistent oversight with the goal of reducing variation in the quality of care.
- 5.109 We understand that these proposals come following an extraordinarily challenging year for adult social care, which is why our initial focus will be to improve the

quality, timeliness and accessibility of adult social care data, with the assessment and intervention elements to be introduced over time as the final element of the assurance framework.

### **Provide a power for the Secretary of State for Health and Social Care to make payments directly to providers**

- 5.110 The Coronavirus pandemic has demonstrated the need for speed and flexibility in providing support to the social care sector. Coronavirus has also clearly demonstrated how unforeseen and quickly changing circumstances may require fast intervention. We are therefore legislating to amend the Health and Social Care Act 2008 to expand the powers of the Secretary of State for Health and Social Care, which currently allows the Secretary of State to make payments to not-for-profit bodies engaged in the provision of health or social care services in England. The Bill will widen this to allow direct payments to be made to any bodies which are engaged in the provision of social care services in England.
- 5.111 The Bill will not prescribe in what circumstances the power can be used, or how it should be provided. Instead, this power will act as a legal foundation for future policy proposals.
- 5.112 The type of payment will be determined on a case-by-case basis. However, we are clear that this power will not be used to amend or replace the existing system of funding adult social care, where funding for state provision is provided via local authorities, largely through local income, and supplemented by government grant funding. Instead, it will only be used in exceptional circumstances.

### **Discharge to assess**

- 5.113 We will bring forward measures to update approaches to hospital discharge to help facilitate smooth discharge, by putting in place a legal framework for a 'Discharge to Assess' model, whereby NHS continuing healthcare (CHC) and NHS Funded Nursing Care (FNC) assessments, and Care Act assessments, can take place after an individual has been discharged from acute care. This will replace the existing legal requirement for all assessments to take place prior to discharge.
- 5.114 This change will help to embed good practice guidelines which have been followed over the past few years. Providing a legal framework for this model allows for the safe discharge of individuals into an environment familiar to them, enabling a more appropriate and accurate evaluation of an individual's care and support needs. Discharge to Assess will not change the thresholds of eligibility for CHC or support through the Care Act or increase financial burdens on local authorities.



5.115 As a requirement to assess prior to discharge is removed, the system of discharge notices, and associated financial penalties, will no longer be required, and will also be removed by this legislation.

### **A standalone power for the Better Care Fund**

5.116 As set out above, legislation will be amending the process for setting the NHS mandate so that it is no longer set on a rolling annual basis. Currently the allocation of the Better Care fund is tied to this annual process. As such, we will be creating a standalone legislative power to support the Better Care Fund and separate it from the mandate setting process.

5.117 This will be a technical change, and will not have any impact on the function, purpose or policy intention for the fund.

### **Proposals relating to public health**

5.118 Alongside the Government's proposals for the future design of the public health system, including the creation of the National Institute for Health Protection (NIHP) and the closure of Public Health England, we are bringing forward a range of targeted proposals in primary legislation relating to public health. Taken together, the proposals will strengthen local public health systems, improve joint working on population health through ICSs, reinforce the role of local authorities as champions of health in local communities, strengthen the NHS's public health responsibilities, strengthen the role of the Department of Health and Social Care in health improvement, and drive more joint working across government on prevention.

5.119 We are also taking measures to intervene in one of the biggest health problems this country faces: obesity; recognising that there is an opportunity to help people make better informed food choices and to help them improve their health.

5.120 Fluoride is a naturally occurring substance that has been shown to improve oral health. We will work to streamline the process for initiating proposals for new schemes for fluoridation of water in England by moving the responsibilities for doing so from local authorities to central government.

### **Public Health power of direction**

5.121 Under existing legislation in section 7A of the 2006 Act, the Secretary of State for Health and Social Care can make arrangements for his public health functions to be exercised by other bodies including NHS England. Currently, this delegation is made by agreement by way of the ['NHS Public Health Functions Agreement'](#) which is made annually between the Secretary of State and NHS England for

commissioning a range of public health services, often referred to as 'section 7A services'.

- 5.122 Under this agreement, NHS England currently commissions a range of services which include national immunisation programmes; national population screening programmes; child health information services; public health services for adults and children in secure and detained settings in England; and sexual assault services (sexual assault referral centres).
- 5.123 The annual NHS Public Health Functions Agreement process is seen as a helpful mechanism for collaborative working; adding value to the health service and providing a framework for delegating delivery of key programmes. However, the Secretary of State cannot require NHS England to take the delegated function. This limits his options to deliver better care and value for patients and the taxpayer in a timely manner.
- 5.124 As such, our proposal is to create a power for the Secretary of State for Health and Social Care to require NHS England to discharge public health functions delegated by the Secretary of State alongside the existing section 7A provisions (which will be retained as they have application to a wider range of bodies and, in general, are an effective mechanism in most circumstances).
- 5.125 In common with the proposed power of direction in respect of NHS England's other functions, this includes scope to direct as to how those delegated functions are to be exercised.
- 5.126 During the pandemic we have seen the increased need to ensure join up between our NHS and public health sectors. By having this power, we will enhance the ability to facilitate urgent updates or rapid service change when needed.

## **Obesity**

- 5.127 Obesity is one of the biggest health problems this country faces. The number of children admitted to hospital for obesity and related conditions has quadrupled in the last decade. Individuals who are obese in their early years are more likely to become obese adults, putting them at a higher risk of ill-health, such as heart disease, type 2 diabetes, several types of cancer and fatty liver disease, and premature death. Evidence also shows that people living with obesity are significantly more likely to become seriously ill and be admitted to intensive care with Covid-19 compared to those with a healthy weight. The need to act now and tackle obesity is clear.
- 5.128 Building on the Government's obesity strategy, [Tackling obesity: empowering adults and children to live healthier lives](#), we want to help people make better

informed food choices and to help them improve their own health. We are making several changes to legislation to support the government's ambitions to halve childhood obesity by 2030, to reduce the number of adults living with obesity and to reduce health inequalities.

- 5.129 We are proposing to amend section 16 of the Food Safety Act 1990 to give ministers the power to amend the EU Food Information to Consumers (2011/1169) regulations that have been transposed into UK law. This will allow ministers to introduce new strengthened labelling requirements that best meet the needs of the consumer to make more informed, healthier choices subject to approval by Parliament.
- 5.130 This power will enable the swift introduction of key obesity strategy policies such as changes to our front-of-pack nutrition labelling scheme and mandatory alcohol calorie labelling, following consultation. We are considering the impact of this clause with the devolved administrations and will continue to engage them on our current and any future policy proposals.
- 5.131 It is the government's intention to introduce further advertising restrictions to prohibit advertisements for products high in fat, sugar or salt (HFSS) being shown on TV before 9pm. In November and December 2020, we consulted on how to go further and implement an online restriction for HFSS advertisements. Depending on the outcome of this consultation, it is our intention to take forward further online advertising restrictions simultaneously in this legislation.

## **Water Fluoridation**

- 5.132 Water Fluoridation is clinically proven to improve oral health and reduce oral health inequalities. It has a protective effect which reduces the impact of a high sugar diet or poor oral hygiene. Around 10% of the population of England currently receive fluoridated water. In the most deprived areas fluoridation of water has been shown to reduce tooth decay in 5-year olds by a third.
- 5.133 Since 2013, local authorities have had the power to propose, and consult on, new fluoridation schemes, variations to existing schemes, and to terminate existing schemes. The Secretary of State for Health and Social Care has responsibility for approving any proposals submitted by local authorities. Local authorities have reported several difficulties with this process including the fact that local authority boundaries are not co-terminous with water flows, which requires the involvement of several authorities in these schemes, in a way which is complex and burdensome. In addition, local authorities are responsible for the oversight of

revenue and costs associated with new proposals, including feasibility studies and consultations, while having no direct financial benefit from any gains in oral health.

- 5.134 In light of these challenges, we are proposing to give Secretary of State for Health and Social Care the power to directly introduce, vary or terminate water fluoridation schemes. The Secretary of State for Health and Social Care already has the existing power to decide on whether proposals for water fluoridation should be approved and responsibility for the administration of schemes.
- 5.135 This removes the burden from local authorities and will allow the Department of Health and Social Care to streamline processes and take responsibility for proposing any new fluoridation schemes, which will continue to be subject to public consultation. Central government will also become responsible for the associated work, such as the cost of consultations, feasibility studies, and the capital and revenue costs associated with any new and existing schemes.
- 5.136 As is the case now, once a scheme is agreed, the agreements held with the water companies will continue to be held centrally.

### **Proposals relating to safety and quality**

- 5.137 The government recognises that any health and care reforms must have safety and quality at their core. Legislative changes to wider structures should enhance and support improvements in these areas. The government is therefore proposing to take the opportunity of legislation to bring forward a range of proposals to support and enhance safety and quality in the provision of healthcare services.
- 5.138 The quality and safety measures in the Bill are about transparency and accountability to the public and patient. They build on work of recent years that now needs urgent legislative underpinning to ensure this openness and accountability is embedded into the structure and culture of the NHS via the establishment of an independent Health Services Safety Investigations Body. This will be complemented by proposals on professional regulation, which seek powers to make it easier to ensure that professions protected in law are the right ones and that the level of regulatory oversight is proportionate to the risks to the public, now and in the future. We are introducing a medical examiner system for the purpose of scrutinising all deaths which do not involve a coroner. This will improve the accuracy of cause of death and mortality statistics; increase transparency for the bereaved; and help deter criminal activity and poor practice. We are also proposing to allow the MHRA to develop and maintain publicly funded and operated medicine registries and to work with the NHS to populate and maintain them where there is a clear patient safety or other important clinical interest.

5.139 Taken together, this much needed package of improvements will bolster safety and quality in the NHS, ensuring that patients can have confidence that the care they receive is of the highest quality; that the professions they receive it from are regulated well; that all deaths are scrutinised in as transparent a manner as possible; and that we have the best data available about the medicines they are prescribed.

### **Health Service Safety Investigations Body**

5.140 The Health Service Safety Investigations (HSSI) Bill was introduced in October 2019. We are intending to bring the provisions from the HSSI Bill into the Health and Care Bill.

5.141 Our provisions propose the establishment of a new independent body, the Health Services Safety Investigations Body (HSSIB) to investigate incidents which have or may have implications for the safety of patients in the NHS. This body will be established as an Executive Non-Departmental Public Body with powers to investigate the most serious patient safety risks to support system learning. Independence as a concept is fundamentally important to HSSIB as it will be a crucial way of ensuring that patients, families and staff have trust in its processes and judgements. Investigation reports will make recommendations and require organisations to publicly respond to these measures, within a specified timescale.

5.142 This proposal will:

- prohibit disclosure of information held by the HSSIB in connection with its investigatory function save in limited circumstances set out in the Bill. The aim is to create a 'safe space' whereby participants can provide information to the HSSIB for the purposes of an investigation in confidence and therefore feel able to speak openly and candidly with the HSSIB.
- encourage the spread of a culture of learning within the NHS through promoting better standards for local investigations and improving their quality and effectiveness. To this end the HSSIB will provide advice, guidance and training to organisations.

5.143 The Health Service Safety Investigations Body (the HSSIB) will continue the work of the Healthcare Safety Investigations Branch (HSIB) which became operational in April 2017 as part of NHS Improvement, to conduct high-level investigations into patient safety incidents in the NHS.

5.144 We are responding to concerns raised during the HSSI Bill's first Parliamentary Passage and plan to amend the Bill provision to extend HSSIB's remit to cover healthcare provided in and by the independent sector.

- 5.145 In addition, we are also introducing a power to enable the Secretary of State for Health and Social Care to require the HSSIB to investigate particular qualifying incidents or groups of qualifying incidents.
- 5.146 We will also be including a regulation-making power allowing Secretary of State to set out additional circumstances when the prohibition on disclosure (safe space) does not apply.
- 5.147 The devolved administrations have previously been involved in policy discussions prior to introduction in October 2019, and we will continue to engage with them on any proposed amendments as this work progresses further.

### **Professional regulation**

- 5.148 Professional regulation assures the public that those providing healthcare are qualified, capable and competent to provide safe and effective care. When healthcare professionals do not meet these standards, professional regulators must act to protect the public.
- 5.149 The UK model of professional regulation for healthcare professionals has become increasingly rigid, complex and needs to change to better protect patients, support the provision of health services, and help the workforce better meet current and future challenges.
- 5.150 The proposed powers will make it easier to ensure that professions protected in law are the right ones and that the level of regulatory oversight is proportionate to the risks to the public, now and in the future. This is not about deregulation – we expect the vast majority of professionals such as doctors, nurses, dentists and paramedics will always be subject to statutory regulation. But this recognises that over time and with changing technology the risk profile of a given profession may change and while regulation may be necessary now to protect the public, this may not be the case in the future.
- 5.151 These proposals form part of a wider programme to create a more flexible and proportionate professional regulatory framework that is better able to protect patients and the public. This will enable regulators to ensure that the processes that professionals have to go through to join and stay on a register are proportionate to assure public safety and are not overly bureaucratic.
- 5.152 This reform programme is being taken forward on a four-country basis and we are continuing to engage with the devolved administrations as we take this work forward. We are aiming to consult on our broader reform proposals, which will be delivered through secondary legislation, shortly.

5.153 At present, section 60 of the Health Act 1999 provides powers to make a large number of changes to the professional regulatory landscape through secondary legislation. The proposals in the Health Bill for additional powers will widen the scope of section 60 and enable the Secretary of State for Health and Social Care to make further reforms to ensure the professional regulation system delivers public protection in a modern and effective way and, that professions are regulated in the most appropriate and cost effective manner.

5.154 The proposal includes:

(a) the power to remove a profession from regulation.

- Statutory regulation should only be used where it is necessary for public protection. The level of regulatory oversight for each profession should be proportionate to the activity carried out and the risks to patients, service users and the public.
- The landscape of the health and social care workforce is not static, and risks will change over time as practices, technology and roles develop. While statutory regulation may be necessary now for a certain profession, over time the risk profile may change, such that statutory regulation is no longer necessary.
- A provision to enable the removal of a profession from statutory regulation through secondary legislation will make it easier to ensure that the protections and regulatory barriers that are in place remain proportionate for all health and care professions.

(b) the power to abolish an individual health and care professional regulator.

- There is inevitable duplication in having nine regulatory bodies (10 including Social Work England) performing similar functions in relation to different professions. A reduction in the number of regulators would deliver public protection in a more consistent way, while also delivering financial and efficiency savings. Powers under section 60 already allow for the creation of new regulators through secondary legislation. However, it is not possible to use these powers to close a regulator.

5.155 This change would allow the Secretary of State to exercise this power and enable Parliament to abolish a regulator using secondary legislation, where its regulatory functions have been merged into or subsumed by another body or bodies, or where the professions that it regulates are removed from regulation.

5.156 Reducing the number of regulators is consistent with proposals set out in the July 2019 [Government response](#) to the [Promoting professionalism, reforming regulation](#) consultation. The Secretary of State for Health and Social Care committed to reviewing the number of health and care professional regulators in the November 2020 [Busting Bureaucracy](#) policy paper.

(c) The power to remove restrictions regarding the power to delegate functions through legislation

- Regulators are currently restricted from delegating to another body some of their core functions. This includes the keeping of a register of persons permitted to practise; determining standards of education and training for admission to practise; giving advice about standards of conduct and performance; and administering procedures relating to misconduct and unfitness to practise.
- The removal of these restrictions would enable a single regulator to take on the role of providing a function across some or all regulators. This would enable one regulator to run the registration function on behalf of others to provide a single process for all registrants to follow, which could reduce duplication and costs for registrants. This will help to deliver public protection in a more consistent fashion and may also increase efficiency. Where a function is delegated, the delegating regulator would retain responsibility for that function.

(d) Clarifying the scope of section 60 to include senior NHS managers and leaders and other groups of workers

- Clarifying the definition of professions covered by Section 60 to include senior managers and leaders and other groups of workers would enable us to extend regulation to those groups in the future. We will continue to ensure that regulation is only used where public protection cannot be assured in other ways, such as through employer oversight.
- The [2019 Kark Review](#) of the fit and proper persons test recommended putting in place stronger measures to ensure that NHS senior managers and leaders have the right skills, behaviours and competencies and that those who are unsuitable to work in such roles are unable to do so. However, the Kark Review stopped short of recommending full statutory regulation and NHS Improvement is currently considering how best to achieve this through non-statutory means.
- While there are no plans at this stage to statutorily regulate senior NHS managers and leaders, clarifying the scope of professions who can be



regulated using the powers in Section 60 of the Health Act 1999 to include these groups would enable this to be brought forward in the future, if further measures are needed following those currently being proposed by NHS England/Improvement to address the concerns raised in the Kark Review.

### **Medical examiners**

- 5.157 Previously included in the above mentioned HSSI Bill, with this proposal we plan to amend existing legislation to establish a statutory medical examiner system within the NHS for the purpose of scrutinising all deaths which do not involve a coroner. We support the recommendations of a number of inquiries, including the Shipman Inquiry, to create a new rigorous and unified system of death certification in England.
- 5.158 This proposal will amend the Coroners and Justice Act 2009 to allow for NHS bodies, rather than local authorities, to appoint Medical Examiners. Once in place, we want to ensure that every death in England and Wales is scrutinised, either by a coroner or a medical examiner. The medical examiner system will improve the accuracy of the cause of death and subsequently mortality statistics and will increase transparency for the bereaved and help deter criminal activity and poor practice.

### **Medicines and Healthcare products Regulatory Agency (MHRA) new national medicines registries**

- 5.159 Medicines registries can consolidate prescribing data for specific medicines with data from clinical care and other social administrative databases and can be further developed to capture more detailed and bespoke data on the cohorts of patients receiving these medicines. The data captured in a specific medicine registry can help support the safe use of the medicine.
- 5.160 The aim is to enable the establishment and operation of a comprehensive medicine information system, including data collection from private providers, which will support UK wide medicine registries. Medicine registries have the potential to be an important tool to support improving post-market surveillance of the use of medicines and help ensure consistent implementation of the highest standards of care.
- 5.161 This proposal will allow the MHRA to develop and maintain publicly funded and operated medicine registries so that we can provide patients and their prescribers, as well as regulators and the NHS, with the evidence they need to make evidence-based decisions.

- 5.162 The MHRA can already request for marketing authorization holders (for example, a pharmaceutical firm which sells a medicine in the UK) to capture data to address specific gaps in knowledge regarding the use, safety and effectiveness of medicines.
- 5.163 However, the registries created and controlled by marketing authorization holders have not always delivered the required evidence in reasonable time frames. There is an opportunity to capitalise on the increasing volume of data routinely captured and linked across the healthcare system to build high quality sustainable registries that can deliver for all patients. These legislative changes will allow the MHRA to set up registries themselves, and work with NHS to populate and maintain them where there is a clear patient safety or other important clinical interest. Registries would be established for a medicine where the public need is clear and the benefits of a publicly held national registry that can access routinely collected data where it is available are required. For example, where we know risks of a medicine can result in serious adverse health outcomes and consistent adherence to risk minimisation measures is critical, or where there are substantive unknowns about the safety or effectiveness of a medicine in a population and urgent evidence is required to support safe access to it.
- 5.164 Where a safety issue has led to the introduction of measures to minimise risk to patients, statutory registries with mandated inclusion of data will facilitate the early identification and investigation of potential non-compliance so that additional action can be taken by regulators in conjunction with health service providers at a national, local, or individual patient level. Registries will help understand the impact of changes in risk minimisation measures on the health of patients and help us to understand how to ensure regulatory actions taken to support patient safety and clinical effectiveness are as effective as possible. Registries will also provide an opportunity for patients to actively contribute information on their experiences with specific medicines bringing focus to the safety and clinical effectiveness issues that impact most on their lives.

### **Hospital food standards**

- 5.165 The Independent Review of NHS Hospital Food published on the 26th October 2020 recommended for improved NHS food and drink standards for patients, staff and visitors to be put on a statutory footing. We support this recommendation and believe that putting hospital food standards on a statutory footing will deliver for the first time, mandatory minimum standards for the provision of good hydration and nutrition in the NHS.
- 5.166 Adopting statutory standards will also provide NHS hospital staff with improved access to healthier options and instil greater confidence in the public that the NHS

is committed to deliver appropriate levels of nutrition and hydration, as well as good quality food.

- 5.167 We propose to grant the Secretary of State for Health and Social Care powers to adopt secondary legislation that will implement the national standards for food across the NHS.

### **Reciprocal healthcare agreements with Rest of World countries**

- 5.168 The UK has multiple reciprocal healthcare agreements with countries outside the EEA and Switzerland ('Rest of World countries'), such as Australia and New Zealand. However, without financial reimbursement or data sharing mechanisms, these agreements are limited in scope and reach.
- 5.169 In line with the Government's Global Britain strategy, looking to invest and strengthen the UK's relationships with countries across the globe and strengthen international healthcare cooperation, the proposed legislation will enable the government to implement more comprehensive reciprocal healthcare agreements with Rest of World countries subject to negotiations. Under the current legislation, the UK is limited to implementing such arrangements with the EU, EEA, EFTA blocs or their Member States. This would offer the opportunity to strengthen existing agreements with Rest of World countries and agree new reciprocal healthcare arrangements with Rest of World countries of strategic importance.
- 5.170 Comprehensive reciprocal healthcare agreements with Rest of World countries could make healthcare more accessible for UK residents when they travel abroad for tourism or short-term business purposes and support individuals with long-term conditions who usually pay higher travel insurance premia or face difficulties in getting comprehensive insurance cover. They can also foster closer collaboration on healthcare with our international partners, supporting improved health outcomes for all.
- 5.171 In addition to supporting people access necessary healthcare, the proposed legislation will enable other advantages for agreements with Rest of World countries:
- The introduction of a reimbursement mechanism means that healthcare costs could be covered, so that no healthcare system will be left worse-off.
  - The exchange of data between countries for the purposes of reimbursement will allow for constant monitoring and evaluation of the cost-effectiveness of these agreements over time.

- The responsibility for paying healthcare charges will lie with governments, thus guaranteeing income for the NHS while eliminating most of the financial burden for the traveller.

5.172 The scope for any new agreements will be agreed across relevant government departments and will be tailored to meet our national interest with input from the devolved administrations as well as relevant operational partners.

## 6. Annex B: Integration, partnerships and accountability

### Working together

- 6.1 Healthy, fulfilled, independent and longer lives for the people of England will require health and care services, local government, NHS bodies, and others to work ever more closely together. Different professions, organisations, services and sectors will work with common purpose and in partnership. This will be especially important when we seek to focus on the people and communities that are most in need of support.
- 6.2 In many ways, the professionals are ahead of the organisations. Multi-disciplinary working has been a recognised part of good care for many years now. But the organisations are catching up. We have seen real advances in recent years in forms of joint working, with a great deal of commitment in parts of local government and the NHS to developing broadly-based 'integrated care systems', many of which are now starting to make a real difference.
- 6.3 One of the most impressive and heartening features of the work to develop integrated care systems has been the emphasis on shared purpose over structures and titles. We are very mindful that any statutory framework for integrated care should preserve, spread and enhance this feature. The point was summed up with great clarity in the recent consultation on integrated care issued by NHS England which set out the following four purposes for systems:
- (a) Improving population health and healthcare;
  - (b) Tackling unequal outcomes and access;
  - (c) Enhancing productivity and value for money; and
  - (d) Helping the NHS to support broader social and economic development.
- 6.4 These purposes provide both a formidable challenge and an excellent basis for collaborative working. Much of this work is happening at the level of 'place'.

### The primacy of place

- 6.5 Many people who are making integration happen emphasise the importance of 'place' (which is most usually aligned with either CCG or local authority

boundaries) in the joining up of services to support people to live well. The most successful integrated care systems have often concentrated on developing the places within their wider geography to thrive and to find shared priorities to work on. Many provider organisations and groupings of organisations such as primary care networks look to their 'place' as their primary focus.

- 6.6 Places vary by population and geography, and they also vary in the history and strength of the connections between the key agencies that make joined up services and improvement to outcomes happen. It is vital that we recognise this as it gives us both assets and challenges: we must not damage the former in tackling the latter (as can happen when reform is attempted). This has led us – building on the experience of those making integrated care happen - to think hard about the right balance between what needs to be prescribed by legislation and other means and what should rightly be left to local and system level decisions.

## **Two forms of integration**

- 6.7 The increased importance of integration within health and social care, is, of course, driven by the vital importance of arranging care around people and the complete picture of their health and care needs, as well as the wider demographic imperatives of getting ahead of the curve on prevention and of supporting people with multiple health and care needs (especially in later life and especially in disadvantaged communities). It is also, as the third of the purposes set out by NHS England notes, about ensuring that we get the best possible value for money for the people we serve – the patients, service users and taxpayers of England.
- 6.8 As is described elsewhere in this paper, we intend to introduce legislation that removes the needless bureaucracy that has grown up around the commissioning framework for the NHS. This will allow the NHS to shift away from an adversarial and transactional system centred on contracting and activity payments to one that is far more collaborative and dedicated to tackling shared problems. While NHS provider organisations will retain their current structures and governance, they will be expected to work in close partnership with other providers and with commissioners or budget holders to improve outcomes and value. This is what the best organisations already do, and the work of early wave integrated care systems in recent years has shown how a collaborative approach can work well - even in a framework that was not specifically designed to support it.
- 6.9 There are, then, two forms of integration which will be underpinned by the legislation: the integration within the NHS to remove some of the cumbersome boundaries to collaboration and to make working together an organising principle; and the integration between the NHS and others, (principally local authorities), to deliver improved outcomes to health and wellbeing for local people.

- 6.10 This adds complexity and will require thoughtful handling within systems with respect to governance and accountability; but we need both forms of integration if we are to achieve the improvements in outcomes that we seek. A more internally collaborative NHS will be a better, more coherent partner for local government and others. A wider partnership that includes local government and which enables a shift towards population health will deliver health, care and economic benefits and contribute to the levelling up agenda as well.
- 6.11 There is an important difference between the NHS and local government: each has a distinct line of accountability. Local government is, of course, held to account by local people and their elected representatives. NHS services and organisations are scrutinised by local authority overview and scrutiny committees and work with them closely on a number of issues – but their primary form of democratic accountability is (via NHS England) to national government and ultimately to Parliament. This will be important to recognise and reflect in the legislation but, as the pioneer ICSs have shown, it is no barrier to shared purpose, shared leadership and the pursuit of outcomes and service integration to improve the lives of local people.

## **The role of legislation**

- 6.12 The purpose of legislation in this context is to create an enabling framework for local partners to either build upon existing partnerships at place and system levels or, where these partnerships are yet to form in earnest, to begin the work of aligning services and decision making in the interests of local people.
- 6.13 The three factors that frame our proposed approach are:
- (a) The importance of shared purpose within places and systems;
  - (b) The recognition of variation – some of it warranted – of form and in the potential balance of responsibilities between places and the systems they are part of;
  - (c) The reality of differential accountabilities, including the responsibility of local authorities to their elected members and the need for NHS bodies to be able to account for NHS spend and healthcare delivery and outcomes.
- 6.14 Legislation in this context needs to be used in a targeted way and in conjunction with a great deal of local and system level freedom to make arrangements that work for all partners. We will not, for example, be making any legislative provision about arrangements at place level- though we will be expecting NHSE to work with ICS NHS bodies on different models for place-based arrangements.

- 6.15 NHS England's November consultation on integrated care generated a large number of responses from individuals and key organisations. It concluded that the government should bring forward legislation to underpin ICSs; that the legislation should allow a significant degree of local flexibility; and should not undermine effective place-based arrangements. It also recommended that ICSs should be underpinned by both an NHS ICS statutory body, with stronger responsibilities for commissioning primary medical, dental, ophthalmology and pharmaceutical services, and a wider statutory health and care partnership.
- 6.16 Having considered the response to the NHS England consultation, the government has concluded that the allocative functions of CCGs should be held by a system level body responsible for integrated care - what we are calling an ICS NHS Body.
- 6.17 Many of the responses served to reinforce the importance of the key factors for framing legislation set out above. As the response from The King's Fund noted 'We also recognise that there is a careful balance to be struck between using legislation to clarify and improve accountability and transparency, while also creating the flexibilities to allow systems to develop the arrangements best suited to their local contexts and population needs. Difficult trade-offs will be involved in resolving some of the issues we have highlighted in this section and we do not underestimate the complex nature of the decisions involved in doing so'.
- 6.18 These considerations have led us to the following model:
- (a) Place based arrangements between local authorities, the NHS and between providers of health and care services are at the core of integration and should be left to local organisations to arrange. We expect local areas to develop models to best meet their local circumstances. We would expect NHS England and other bodies to provide support and guidance, building on the insights already gained from the early wave ICSs. The statutory integrated care system (ICS) will also work to support places within its boundaries to integrate services and improve outcomes – recognising that different places will be at different stages of development and face different issues.
  - (b) Health and Wellbeing Boards will remain in place and will continue to have an important responsibility at place level to bring local partners together, as well as developing the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy, which both HWBs and ICSs will have to have regard to. We will support HWBs and ICSs, including with guidance, to work together closely to complement each other's roles, and to share learning and expertise.
  - (c) A statutory ICS will be formed in each ICS area. These will be made up of a statutory ICS NHS body and a separate statutory ICS Health and Care Partnership, bringing together the NHS, local G



- (d) government and partners e.g. community health providers. We would expect the public name of each ICS NHS Body to reflect its geographical location – for example, NHS Nottinghamshire or NHS North West London.
- (e) The ICS NHS Body will take on the commissioning functions of the CCGs and some of those of NHS England within its boundaries, as well as CCG’s responsibilities in relation to Oversight and Scrutiny Committees. It will not have the power to direct providers, and providers’ relationships with CQC will remain unchanged.
- (f) Each ICS NHS body will have a unitary board, and this will be directly accountable for NHS spend and performance within the system, with its Chief Executive becoming the Accounting Officer for the NHS money allocated to the NHS ICS Body. The board will, as a minimum, include a chair, the CEO, and representatives from NHS trusts, general practice, and local authorities, and others determined locally for example community health services (CHS) trusts and Mental Health Trusts, and non-executives. ICSs will also need to ensure they have appropriate clinical advice when making decisions. NHSE will publish further guidance on how Boards should be constituted, including how chairs and representatives should be appointed.
- (g) The ICS NHS body will be responsible for the day to day running of the ICS, and NHS planning and allocation decisions. It will be responsible for:
  - developing a plan to address the health needs of the system;
  - setting out the strategic direction for the system; and
  - explaining the plans for both capital and revenue spending for the NHS bodies in the system.

6.19 Discussions with a number of stakeholders including the Local Government Association has led us to the conclusion that there is a strong case for the governance arrangements for an ICS to include an ICS Health and Care Partnership made up of a wider group of organisations than the ICS NHS 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 ICS NHS Body and local authority would have to have regard to this plan. The Health and Care 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.

6.20 Members of the ICS Health and Care Partnership could be drawn from a number of sources including Health and Wellbeing Boards within the system, partner

organisations with an interest in health and care (including Healthwatch, voluntary and independent sector partners and social care providers), and organisations with a wider interest in local priorities (such as housing providers). Our intention is to specify that an ICS should set up a Partnership and invite participants, but we do not intend to specify membership or detail functions for the ICS Health and Care Partnership - local areas can appoint members and delegate functions to it as they think appropriate.

- 6.21 The ICS Health and Care Partnership could also be used by NHS and Local Authority Partners as a forum for agreeing co-ordinated action and alignment of funding on key issues, and this may be particularly useful in the early stages of ICS formation. We will, working with NHSE and the LGA, also issue guidance to support ICSs in establishing these bodies. This, along with the flexibilities at place level, will allow systems to decide how much or how little to do at these different levels and will also potentially allow them to vary these arrangements over time as the system matures and adapts. We know that this element of flexibility has been of value to the early wave ICSs where there are many (and different) examples of partnership boards and of arrangements at place level. In many cases, partnership boards have served as a way to identify, develop and drive shared priorities and projects between local government and NHS partners.
- 6.22 Taken together, we think these arrangements provide the right balance between recognising the distinctive accountabilities and responsibilities of the NHS, local authorities and other partners while also strongly encouraging areas to go further in developing joint working and decision-making arrangements that deepen and improve over time in the interests of local people.

## 7. Annex C: Stakeholder Engagement

7.1 Despite the unprecedented context under which we have developed this paper, we have still managed to engage with a range of stakeholders from across the health and care system, both through roundtables and smaller discussions.

7.2 We would like to extend our sincere thanks to the following organisations for discussing the themes and proposals at the centre of this paper with us.

- Academy of Medical Royal Colleges
- Age UK & Care Support Alliance
- Alzheimer's Society
- Association of Directors of Adult Social Services (ADASS)
- Association of Directors of Public Health
- Association of Pharmacy Technicians
- British Medical Association
- Care England
- Care Providers Alliance
- Care Quality Commission
- Care UK
- Carers UK
- Centre for Ageing Better
- Centre for Mental Health
- Faculty of Public Health
- Health Education England
- Health Foundation
- Healthcare Safety Investigation Branch

- Healthwatch England
- Independent Healthcare Provider Network
- Institute for Government
- International Longevity Centre UK
- Learning Disability England
- Local Government and Social Care Ombudsman
- Local Government Association
- National Association of Primary Care
- National Care Forum
- National Data Guardian
- National Voices
- NHS Assembly
- NHS Blood and Transplant
- NHS Business Services Authority
- NHS Clinical Commissioners
- NHS Confederation
- NHS Digital
- NHS Employers
- NHS England
- NHS Improvement
- NHS Providers
- NHS Resolution
- National Institute for Health and Care Excellence

- Nuffield Trust
- Policy Exchange
- Public Health England
- Royal College of General Practitioners
- Royal College of Nursing
- Royal Pharmaceutical Society
- Social Care Institute for Excellence
- Skills for Care
- SOLACE
- The King's Fund
- The Patients Association
- Think Local Act Personal
- UK Home Care Association
- UNISON



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# Proposed modification of the NHS provider licence standard conditions: Condition G4 (fit and proper persons)

## Consultation notice

22 February 2021



# About this document

1. This statutory consultation notice published by Monitor under section 100 of the Health and Social Care Act 2012 (the 2012 Act) gives notice of a proposed modification to the standard conditions of the NHS provider licence. It should be read in conjunction with the annexes which are supporting documents.
2. Monitor and the NHS Trust Development Authority operate as an integrated organisation known as NHS Improvement. In this document references to 'NHS Improvement' should be read as references to Monitor and/or the Trust Development Authority as appropriate to the context. References to 'directors', even where expressly stated, include all those performing equivalent or similar functions.

## Background

3. Providers of healthcare services for the NHS must ensure that their directors (or directors and governors in the case of NHS foundation trusts) satisfy specified requirements. In particular, directors must meet the fit and proper person test set out in regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the FPP Regulations). A copy of regulation 5 of the FPP Regulations can be found at Annex B.
4. NHS foundation trusts and most independent providers of health care services for the NHS must be licensed by Monitor. NHS trusts are not required to hold a licence but are bound by most of the standard conditions of the provider licence, including condition G4. Condition G4 makes provision about fit and proper persons, and therefore applies to NHS foundation trusts, NHS trusts and all licensed independent providers of health services for the NHS.
5. The proposed amendments to condition G4 would provide for consistency with the FPP Regulations.

# Proposed modification to condition G4

6. NHS Improvement proposes modifying standard condition G4 of the provider licence: Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions). A copy of condition G4 in its current form can be found at Annex A. Our proposal is largely a technical amendment designed to align condition G4 with the fit and proper persons requirements set out in the FPP Regulations.

## Reason for the proposed modification

7. Licence condition G4 applies to all providers holding an NHS provider licence and, by way of directions, also applies to NHS trusts. It requires that providers ensure that their directors and governors meet appropriate standards of personal behaviours and technical competence. The objective is to prevent an unfit person from holding office as a director or governor.
8. Since publication of the NHS provider licence, regulation 5 of the FPP Regulations has come into force. Regulation 5 sets out a fit and proper person's test (the FPP test) which applies to directors of all NHS providers registered with the Care Quality Commission, which includes all licence holders and other organisations to which licence conditions apply.
9. To ensure consistency of approach with the FPP Regulations, we propose making some technical amendments to condition G4.
10. Although the FPP Regulations do not apply to governors of NHS foundation trusts, we also propose updating the provisions of condition G4 relating to governors to reflect current practices.

## Effect of the proposed modification

### Provisions relating to directors

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11. While the proposed modification (as it applies to directors) is a technical amendment, it would have the effect of extending the scope of the fit and proper person test as set out in the licence to include:
  - a. qualifications, competence, skills, experience and ability to properly perform the functions of a director
  - b. issues of serious misconduct or mismanagement and
  - c. disbarment in relation to safeguarding vulnerable groups and disqualification from office.
12. In practice, licence holders are already required to comply with these requirements under the FPP Regulations. The effect of the modification is therefore simply to ensure consistency of approach in the provider licence.
13. The modification also removes the requirement for licence holders to ensure that there are contractual arrangements in place for dealing with directors who are unfit. These provisions are no longer necessary since the introduction of the FPP Regulations prohibits licence holders from appointing, or having in office, an unfit director.
14. The effect of the modification is also to remove provisions which have become redundant and brings provisions in line with current working practices, details of which are set out in paragraphs 15 to 18 below.

### Provisions relating to governors

---

15. The FPP Regulations do not apply to governors of NHS foundation trusts. The effect of the proposed modification (as it applies to governors) would be limited to bringing the provisions in line with current working practices, as set out in paragraphs 16 to 18 below, and to make minor changes to the wording to provide greater clarity.

### Provisions relating to directors and governors

---

16. The proposed modification would remove two provisions which are either redundant or have limited application.

17. The first of these provisions is the reference to Monitor’s discretion to authorise any general exception to the fit and proper person requirements for NHS foundation trust directors and governors. This power has limited application because it applies only to fit and proper person requirements that an NHS foundation trust has included in its constitution and which go beyond the legislative requirements. In practice the power has never been used so the modification would simply remove a provision that is already effectively redundant.
18. The second is the prohibition on holding office as a director or governor for any person disqualified from holding office as a director under the Company Directors’ Disqualification Act 1986. As this provision expressly relates to directors’ fitness and goes beyond the legislative framework for governors, it is proposed that it is removed in relation to governors. For directors, the provision can be removed as it is already covered by the FPP test under the FPP Regulations, which would be incorporated into the licence by the proposed modifications.

## Form of the proposed modification to licence condition G4

19. The proposed modification to condition G4 is in the form set out below:

### **PROVIDER LICENCE**

#### **Licence Condition G4**

#### **Condition G4 – Fit and proper persons as Governors and Directors (also applicable to those performing the functions of, or functions equivalent or similar to the functions of, a director)**

1. The Licensee must ensure that a person may not become or continue as a Governor of the Licensee if that person is:
  - (a) a person who has been made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;
  - (b) a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);

- (c) a person who has made a composition or arrangement with, or granted a trust deed for, that person's creditors and has not been discharged in respect of it;
  - (d) a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on that person.
2. The Licensee must not appoint or have in place a person as a Director of the Licensee who is not fit and proper.
3. For the purposes of paragraph 2, a person is not fit and proper if that person is:
- (a) an individual who does not satisfy all the requirements as set out in paragraph (3) and referenced in paragraph (4) of regulation 5 (fit and proper persons: directors) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (S.I. 2014/2936); or
  - (b) an organisation which is a body corporate, or a body corporate with a parent body corporate:
    - i. where one or more of the Directors of the body corporate or of its parent body corporate is an individual who does not meet the requirements referred to in sub-paragraph (a);
    - ii. in relation to which a voluntary arrangement is proposed, or has effect, under section 1 of the Insolvency Act 1986;
    - iii. which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act) appointed for the whole or any material part of its assets or undertaking;
    - iv. which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act;
    - v. which passes any resolution for winding up;
    - vi. which becomes subject to an order of a Court for winding up; or
    - vii. the estate of which has been sequestrated under Part 1 of the Bankruptcy (Scotland) Act 1985.
4. In assessing whether a person satisfies the requirements referred to in paragraph 3(a), the Licensee must take into account any guidance published by the Care Quality Commission.

# The consultation process

## Statutory consultation and objection process

20. Any proposals to modify the standard conditions of the NHS provider licence are subject to a statutory consultation process under the 2012 Act. This provides an opportunity for licence holders to express their views on, and to object to, the proposals. Further information on the statutory consultation and objection process can be found in Annex C.
21. The 2012 Act sets out the statutory process for challenging a proposed modification to the NHS provider licence. If licence holders object to the proposal, and the number of objections reaches a certain threshold, NHS Improvement may not progress with the proposed modification without a reference to the Competition and Markets Authority or further statutory consultation.

## Who can object to the proposed modifications?

22. While responses from stakeholders other than licence holders will inform any decision about the proposed modification, only objections from licence holders will count towards the objection threshold.

## Impact assessment

23. Under section 69 of the 2012 Act, Monitor is required to carry out an impact assessment where proposals are likely to involve a major change in the standard conditions of the NHS provider licence. This proposal involves only minor and technical changes to the NHS provider licence which are necessary to bring the licence into line with existing legislative requirements. On that basis, an impact assessment is not required.
24. We have carried out an assessment of the equality and health inequalities impact of these proposals and have not identified any issues. We would welcome comments from consultees.

## Consultation questions

1. Do you object to the proposed technical amendment to modify condition G4 of the NHS provider licence? *\*All consultation responses will be taken into account but only objections from licence holders will count towards the objection threshold*
2. If so, what are your reasons?
3. Are there any equality issues that arise (positive or negative) in relation to this proposal? In particular, would this proposal have an impact on any groups of persons sharing a protected characteristic, as set out in the Equality Act 2010?
4. If yes, please outline any potential issues.

## Responding to the consultation

25. If you wish to respond to this consultation, please do so by **midnight on Monday 29 March 2021**. You may submit your response via our online survey: <https://www.engage.england.nhs.uk/survey/proposed-modification-of-the-nhs-provider-licence>, or by email to [nhsi.g4responses@nhs.net](mailto:nhsi.g4responses@nhs.net). The address for postal responses can be found at the end of this document.
26. If you are responding to this consultation on behalf of an organisation, please confirm that you are authorised to do so.
27. Please email [nhsi.g4responses@nhs.net](mailto:nhsi.g4responses@nhs.net) if you have any questions or any difficulty accessing the survey. Please let us know (by emailing [nhsi.g4responses@nhs.net](mailto:nhsi.g4responses@nhs.net)) if all or part of your response or identity is confidential so that we can exclude this from any published summary of responses. We will do our best to meet all requests for confidentiality but, because NHS Improvement is a public body subject to the Freedom of Information Act, we cannot guarantee that we will not be obliged to release your response (potentially including your identity) or part of it even if you say it is confidential.

# Annex A: NHS Provider Licence General Condition G4: Fit and Proper Persons as Governors and Directors

## The Provider Licence

### Condition G4: Current form

#### **Condition G4 – Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions)**

1. The Licensee shall ensure that no person who is an unfit person may become or continue as a Governor, except with the approval in writing of Monitor.
2. The Licensee shall not appoint as a Director any person who is an unfit person, except with the approval in writing of Monitor.
3. The Licensee shall ensure that its contracts of service with its Directors contain a provision permitting summary termination in the event of a Director being or becoming an unfit person. The Licensee shall ensure that it enforces that provision promptly upon discovering any Director to be an unfit person, except with the approval in writing of Monitor.
4. If Monitor has given approval in relation to any person in accordance with paragraph 1, 2, or 3 of this condition the Licensee shall notify Monitor promptly in writing of any material change in the role required of or performed by that person.
5. In this Condition an unfit person is:
  - (a) an individual;
    - (i) who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged; or
    - (ii) who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it; or



- (iii) who within the preceding five years has been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him; or
- (iv) who is subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986; or

(b) a body corporate, or a body corporate with a parent body corporate

- (i) where one or more of the Directors of the body corporate or of its parent body corporate is an unfit person under the provisions of subparagraph (a) of this paragraph, or
- (ii) in relation to which a voluntary arrangement is proposed under section 1 of the Insolvency Act 1986, or
- (iii) which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act) appointed for the whole or any material part of its assets or undertaking, or
- (iv) which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act, or
- (v) which passes any resolution for winding up, or
- (vi) which becomes subject to an order of a Court for winding up.

# Annex B: Relevant legislation: the fit and proper persons tests

## Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (FPP Regulations)

5.—

1. This regulation applies where a service provider is a body other than a partnership.
2. Unless the individual satisfies all the requirements set out in paragraph (3), a service provider must not appoint or have in place an individual—
  - a. as a director of the service provider, or
  - b. performing the functions of, or functions equivalent or similar to the functions of a director.
3. The requirements referred to in paragraph (2) are that—
  - a. the individual is of good character,
  - b. the individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed,
  - c. the individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed,
  - d. the individual has not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity, and
  - e. none of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.
4. In assessing an individual's character for the purposes of paragraph (3)(a), the matters considered must include those listed in Part 2 of Schedule 4.

5. The following information must be available to be supplied to the Commission in relation to each individual who holds an office or position referred to in paragraph (2)(a) or —
  - a. the information specified in Schedule 3, and
  - b. such other information as is required to be kept by the service provider under any enactment which is relevant to that individual.
6. Where an individual who holds an office or position referred to in paragraph (2)(a) or (b) no longer meets the requirements in paragraph (3), the service provider must—
  - a. take such action as is necessary and proportionate to ensure that the office or position in question is held by an individual who meets such requirements, and
  - b. if the individual is a health care professional, social worker or other professional registered with a health care or social care regulator, inform the regulator in question.

## **SCHEDULE 4**

### **Good character and unfit person tests**

#### **PART 1**

##### **Unfit person test**

1. The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged.
2. The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.
3. The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986.
4. The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.
5. The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.
6. The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

## **PART 2**

### **Good character**

7. Whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence.
  
8. Whether the person has been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals.

# Annex C: The statutory consultation process and objection threshold

## Consultation process

The Health and Social Care Act 2012 specifies that Monitor must consult on any proposed modification to the standard conditions of the provider licence with:

- every licence holder
- the Secretary of State
- NHS England
- every CCG
- the CQC and its Healthwatch England Committee.

Monitor may only modify the standard conditions of the licence (without reference to the Competition and Markets Authority) if:

- a. No objections are received from licence holders within the notice period (a minimum of 28 days); or
- b. Where one or more licence holders object within the notice period, the objection threshold and share of supply threshold are not met.

The objection threshold is met if 20% or more licence holders object to the proposals. The share of supply threshold is met if the percentage of licence holders, weighted according to share of supply is 20% or more.

## Who can object?

All responses to the consultation will be taken into account but only objections from licence holders will count towards the objection threshold and therefore determine whether NHS Improvement can make the proposed modification without further consultation or reference to the Competition and Markets Authority.

Any objection must be made by a person who is authorised to represent the licence holder. Providers should ensure that there are proper internal processes for managing this.

Licence holders should, if they object to the proposals, provide reasons. Failure to do so will not invalidate the objection but it may have an impact on our assessment of the objection.

Contact us:

[nhsi.g4responses@nhs.net](mailto:nhsi.g4responses@nhs.net)

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Department  
of Health &  
Social Care

# **Integration and Innovation: working together to improve health and social care for all**

Published 11 February 2021

**The Department of Health and Social Care's legislative proposals for a Health and Care Bill**







# **Integration and Innovation: working together to improve health and social care for all**

Presented to Parliament  
by the Secretary of State for Health and Social Care  
by Command of Her Majesty

February 2021

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# Foreword

We are living through the greatest challenge our health and care system has ever faced. Yet even in crisis conditions, everyone working in our health and care system has continued to deliver excellence. Critically, collaboration across health and social care has accelerated at a pace showing what we can do when we work together, flexibly, adopting new technology focused on the needs of the patient, and set aside bureaucratic rules.

This paper sets out our legislative proposals for a Health and Care Bill. It aims to build on the incredible collaborations we have seen through Covid and shape a system that's better able to serve people in a fast-changing world.

At its heart, however, this Bill is about backing our health and care system and everyone who works in it. Our proposals build on the NHS's own – those in the Long Term Plan. We're also outlining steps to support everyone who works to meet people's health and care needs. Taken together, they will help us build back better after Covid.

First, by removing the barriers that stop the system from being truly integrated. We want to help Integrated Care Systems play a greater role, delivering the best possible care, with different parts of the NHS joining up better; and the NHS and local government forming dynamic partnerships to address some of society's most complex health problems. It will help us deliver our Manifesto Commitments, including 50,000 more nurses and 40 new hospitals.

Second, we will use legislation to remove much of the transactional bureaucracy that has made sensible decision-making harder. The reforms will help enable us to use technology in a modern way, establishing technology as a better platform to support staff and patient care. Our proposals will maintain the distinct responsibilities between those who fund services and those who provide care—which has been a cornerstone of efforts to ensure the best value for taxpayers for over thirty years—but sets out a more joined-up approach built on collaborative relationships, so that more strategic decisions can be taken to shape health and care for the decades to come. It's about population health: using the collective resources of the local system, NHS, local authorities, the voluntary sector and others to improve the health of local areas.

Finally, our proposals will ensure a system that is more accountable and responsive to the people that work in it and the people that use it. Ministers have always been accountable, rightly, for NHS performance. Our proposals will ensure NHS England, in a new combined form, is accountable to Government and the taxpayers that use it while maintaining its clinical and day-to-day operational independence. We will introduce measures to enhance quality and safety in the NHS, including the creation of an independent statutory body to oversee safety investigations. Alongside this we will work with Local Authorities to develop enhanced assurance frameworks for social care, that will support improved outcomes and experiences for people and their families.

These legislative measures are intended to support improvements already under way in the NHS. They should be seen in the context of those broader reforms. And they are by no means the full extent of this government's ambition for the nation's health. We will also bring forward changes in social care, public health and mental health. We also remain

committed to the sustainable improvement of adult social care and will bring forward proposals this year. The targeted public health interventions we have outlined here in relation to obesity and fluoridation, sit alongside our proposals for the future design of the public health system, including the creation of the National Institute for Health Protection (NIHP). We are also bringing forward legislation to bring the Mental Health Act up to date, as set out in our White Paper last month.

As we build back better after Covid-19, these proposals can help us look to the decades ahead with confidence. This is a unique moment when we must continue to build on the audacious legacy that makes the NHS the very best of Britain. We must seize it.

# 1. Executive Summary

- 1.1 We are living through the greatest challenge our health and care system has ever faced. The Coronavirus (Covid-19) pandemic caused an unprecedented external shock, bringing intense pressure that could have been devastating to the system itself and to all of us as individuals. And yet, the extraordinary dedication, care and skill of the people who work in our communities and our hospitals has been unwavering, serving as a reminder once again of just how precious our health and care services are to us all.
- 1.2 This is no ordinary moment. We have seen collaboration across health and social care at a pace and scale unimaginable even a little over a year ago. The NHS and social care providers have delivered outstanding care to those in need while at the same time radically changing ways of working, reducing bureaucracy and becoming more integrated. New teams have been built, adoption of new technology has been accelerated, new working-cultures developed, and new approaches to solving difficult problems pursued. As a result, NHS capacity grew; new hospitals were built in just a matter of days; and new ways of treating patients have become the norm. As we look towards the future and to the recovery of our society, our health and care system will continue to be central to our national wellbeing and prosperity in the years ahead.
- 1.3 In recent years, we have seen our health and care system adapt and evolve to meet the challenges facing health systems around the world. Not only is our population growing in size, people are also living longer but suffering from more long-term conditions. One in three patients admitted to hospital as an emergency has five or more health conditions, up from one in ten a decade ago. While smoking rates may be decreasing; diabetes, obesity, dementia and mental health issues are on the rise. Faced with these challenges, as well as those from Covid-19, the case couldn't be clearer for joining up and integrating care around people rather than around institutional silos – care that focuses not just on treating particular conditions, but also on lifestyles, on healthy behaviours, prevention and helping people live more independent lives for longer. We need the different parts of our health and care system to work together to provide high quality health and care, so that we live longer, healthier, active and more independent lives.
- 1.4 And so, this paper sets out our legislative proposals for a Health and Care Bill. Many of the proposals build on the NHS's recommendations in its [Long Term Plan](#), but they are also founded in the challenge outlined above. There will be those who will say that this is simply the wrong time to make any kind of change in health and social care. Even if it will help the professionals who know best to do their jobs better, unhindered by systems and processes that might slow down or even prevent them from doing their jobs in the way they would want to. The

response to Covid-19 is our current priority but we must also prepare for the recovery of our health and care system and learn lessons from this experience. Our legislative proposals capture the learning from the pandemic and are driven by the context of a post-Covid world, which is now in reach. And they make permanent the innovations that Covid-19 has accelerated and encouraged the system to improvise new and better ways of working. Our proposals will help the NHS and local government in the immediate work of recovery from the pandemic by making joint planning and delivery of services easier, and over the long term by helping to address the needs of everyone, from children to older people, at different stages of their lives.

- 1.5 We have seen the brilliance of our doctors, nurses, carers and other healthcare professionals in providing world-class care to those in need. What has gone unseen by many is that in order to provide this level of care the traditional dividing lines between health professionals have been cast aside to allow unprecedented levels of collaboration.
- 1.6 If we are to improve the lives and life-chances of all in this country, no matter where they are from, their ethnicity or social background we must be ready for whatever may come next.
- 1.7 The response to Covid-19 - led by those who know best - has shown us new ways to deliver care using innovative and creative solutions, exploiting the potential of digital and data, instead of needless bureaucracy. We must not go back to the old ways of working. The gains made through these new approaches must be locked in.
- 1.8 The founding principles of the NHS – taxpayer-funded healthcare available to all, cradle-to-grave, and free at the point of delivery – remain as relevant now as they were in 1948. Local government delivery is also rooted in firm foundations: in serving its residents, with strong local democratic accountability, and expertise in the health, public health and care needs of its populations. To protect these principles, which are so close to all our hearts, we must back those who make them a reality every day of their lives - by building and constantly renewing a culture of collaboration.
- 1.9 Integrating care has meant more people are seeing the benefits of joined up care between GPs, home care and care homes, community health services, hospitals and mental health services. For staff, it has enabled them to work outside of organisational silos, deliver more user-centred and personalised approaches to care, and tackle bureaucracy standing in the way of providing the best care for people. It enables greater ambition on tackling health inequalities and the wider determinants of health – issues which no one part of the system can address alone. It both relies on the power of digital and data to join up care and uses that

power to drive transformation of care. The experience of the pandemic has made the case for integrated care even stronger and has redoubled the government's determination to ensure that public health, social care and healthcare work more closely together in the future than ever before.

- 1.10 High-performing teams and organisations have vibrant cultures that create the conditions for people to perform at their very best. They are collaborative and open organisations, people focussed with processes that support rather than suffocate the efforts of individuals to do good work. And so, this White Paper sets out our proposals for legislation to support and enable the health and care workforce, organisations and wider system to work together to improve, integrate and innovate.
- 1.11 In this paper we refer to health and care partners for brevity's sake, but to be clear, we believe that this means everyone who works tirelessly to deliver high-quality care and support to people all over the country, including NHS organisations, local authorities, voluntary partners and charities.

## **Working together to integrate care**

- 1.12 At the heart of the changes being taken forward by the NHS and its partners, and at the heart of our legislative proposals, is the goal of joined up care for everyone in England. Instead of working independently every part of the NHS, public health and social care system should continue to seek out ways to connect, communicate and collaborate so that the health and care needs of people are met. Healthy, fulfilled, independent and longer lives for the people of England will require health and care services, local government, NHS bodies, and others to work ever more closely together. Different professions, organisations, services and sectors will work with common purpose and in partnership. This will be especially important when we seek to focus on the people and communities that are most in need of support.
- 1.13 There are, then, two forms of integration which will be underpinned by the legislation: integration within the NHS to remove some of the cumbersome boundaries to collaboration and to make working together an organising principle; and greater collaboration between the NHS and local government, as well as wider delivery partners, to deliver improved outcomes to health and wellbeing for local people.
- 1.14 The NHS and local authorities will be given a duty to collaborate with each other. We will also bring forward measures for statutory Integrated Care Systems (ICSs). These will be comprised of an ICS Health and Care Partnership, bringing together the NHS, local government and partners, and an ICS NHS Body. The ICS NHS



body will be responsible for the day to day running of the ICS, while the ICS Health and Care Partnership will bring together systems to support integration and develop a plan to address the systems' health, public health, and social care needs. Both bodies will need to draw on the experience and expertise of front-line staff across health and social care. The legislation will aim to avoid a one-size-fits-all approach but enable flexibility for local areas to determine the best system arrangements for them. A key responsibility for these systems will be to support place-based joint working between the NHS, local government, community health services, and other partners such as the voluntary and community sector. Frequently, place level commissioning within an integrated care system will align geographically to a local authority boundary, and the Better Care Fund (BCF) plan will provide a tool for agreeing priorities. This will be further supported by other measures including improvements in data sharing and enshrining a 'triple aim' for NHS organisations to support better health and wellbeing for everyone, better quality of health services for all, and sustainable use of NHS resources.

## **Reducing bureaucracy**

- 1.15 Stakeholders have said that existing legislation is overly detailed and prescriptive in some areas. We intend to reform the existing legislation to support the workforce by creating the flexibility NHS organisations need – to remove the barriers that prevent them from working together and to enable them to arrange services and provide joined up care in the interests of service users. We will put pragmatism at the heart of the system. Enabling the NHS and local authorities to arrange healthcare services to meet current and future challenges by ensuring that public and taxpayer value – and joined up care – are first and foremost. This will require changes to both competition law as it was applied to the NHS in the Health and Social Care Act 2012 and the system of procurement applied to the NHS by that legislation. These changes will enable the NHS and local authorities to avoid needless bureaucracy in arranging healthcare services while retaining core duties to ensure quality and value. This will be supported by further pragmatic reforms to the tariff and to remove the statutory requirement for Local Education and Training Boards.

## **Improving accountability and enhancing public confidence**

- 1.16 We are also bringing forward several measures to improve accountability in the system in a way that will empower organisations and give the public the confidence that they are receiving the best care from their health and care system, every time they interact with it. The de facto development in recent years of a strongly supportive national NHS body in the form of a merged NHS England and NHS Improvement will be placed on a statutory footing and will be designated as

NHS England. This will be complemented by enhanced powers of direction for the government over the newly merged body which will support great collaboration, information sharing and aligned responsibility and accountability. In addition, we will legislate to further ensure the NHS is able to respond to changes and external challenges with agility as needed. Measures will include reforms to the mandate to NHS England to allow for more flexibility of timing; the power to transfer functions between Arm's Length Bodies and the removal of time limits on Special Health Authorities. An improved level of accountability will also be introduced within social care, with a new assurance framework allowing greater oversight of local authority delivery of care, and improved data collection allowing us to better understand capacity and risk in the social care system. Our measures recognise this, and we therefore plan to introduce greater clarity in the responsibility for workforce planning and a clear line of accountability for service reconfigurations with a power for ministers to determine service reconfigurations earlier in the process than is presently possible.

## **Additional measures**

- 1.17 We also intend to bring forward other measures to support social care, public health and the NHS. These are designed to address specific problems or remove barriers to delivery, maximise opportunities for improvement, and have in most cases been informed by the experience of the pandemic.
- 1.18 These measures are not intended to address all the challenges faced by the health and social care system. The government is undertaking broader reforms to social care and public health which will support the system in helping people to live healthier, more independent lives for longer. In particular, the Department recognises the significant pressures faced by the social care sector and remains committed to reform. We want to ensure that every person receives the care they need and that it is provided with the dignity they deserve. We have committed to bringing forward proposals this year but, in the meantime, our legislative proposals will embed rapid improvements made to the system as it has adapted to challenges arising from Covid-19. Similarly, on public health, our experience of the pandemic underlines the importance of a population health approach, informed by insights from data: preventing disease, protecting people from threats to health, and supporting individuals and communities to improve their health and resilience. The government will publish in due course an update on proposals for the future design of the public health system, which will create strong foundations for the whole system to function at its best. But the measures in this legislation will address issues that require intervention through primary legislation.
- 1.19 In social care, we have set out a number of measures that apply the core themes of these proposals set out above in the specific context of social care. Integration

will be enhanced through the position of social care in the ICS structure, a new standalone legal basis for the Better Care Fund and allowing 'Discharge to Assess' models to be followed. A legal power to make direct payments to providers will reduce bureaucracy in providing future additional support to the sector. Finally, an enhanced assurance framework and improved data collection will improve accountability within the social care sector.

- 1.20 For public health, alongside the population health element of our "triple aim", we intend to bring forward measures to: make it easier to secure rapid change updates in NHS England public health functions; help tackle obesity by introducing further restrictions on the advertising of high fat, salt and sugar foods; as well as a new power for Ministers to alter certain food labelling requirements. In addition, we will be streamlining the process for the fluoridation of water in England by moving responsibilities for doing so from local authorities to central government.
- 1.21 Finally, we plan to bring forward measures that contribute to improved quality and safety in the NHS, including placing the Health Services Safety Investigations Body on a statutory footing; establishing a statutory medical examiners system; and allowing the Medicines and Healthcare products Regulatory Agency to set up national medicines registries. We are also putting in place legislation to enable the implementation of comprehensive reciprocal healthcare agreements with countries around the world.

## **Next steps**

- 1.22 As we set out in chapter one, legislation is best seen as an enabler of change that is most effective when combined with other reforms and drivers of change within the health and care system. We have seen the NHS adapt in recent years, developing innovations to support more joined up care and to tackle bureaucracy. This provides a foundation to build upon and our aim is to use legislation to provide a supportive framework for health and care organisations to continue to pursue integrated care and other sources of value for service users and taxpayers in a pragmatic manner. As the system emerges from the pandemic, these legislative measures will assist with recovery by bringing organisations together, removing the bureaucratic and legislative barriers between them and enabling the changes and innovations they need to make.
- 1.23 On current timeframes, and subject to Parliamentary business, our plan is that the legislative proposals for health and care reform outlined in this paper will begin to be implemented in 2022. This means they will form a critical part of the recovery process from the pandemic, and so we must ensure that our approach is enabling and flexible. Many of the lessons of the pandemic are clear, but it will take time to fully understand them all. We need to combine the realism required in recognising

we do not know all the answers with the urgency of working to successfully apply the insights we do have as soon as possible. Legislation can only ever be part of the picture, and will need to support and accompany wider reforms in areas such as data and finance, which will play a key role in the years ahead to meet the changing needs of the population, to deal with the challenges caused by the pandemic, and to tackle the health inequalities exposed by Covid-19.

## 2. The role of legislation

- 2.1 In a typical 24-hour period, the NHS in England will see 1 million patients in GP appointments and carry out over 26,000 operations. In the social care system, local authorities are supporting almost 150,000 older people and over 40,000 young people in care homes as well as over 440,000 people in the community. Councils received 1.9m requests for adult social care support in 2019/20 – equivalent to 5,290 requests for support per day. Behind those numbers there are many stories of hope, vulnerability, care and healing; and of health and care services that have empowered and helped people to live fulfilling lives. These stories are the work of the dedicated staff who make our NHS and our care system what it is, and the real experiences of the people behind the statistics.
- 2.2 How many of those health and care staff on that typical day consult, discuss or even think about the legal framework the health and care system operates within? Or how many people are aware of the patchwork of legislation that applies to the NHS and social care system? Hardly any, of course, and there is no reason why they should. The legal framework for the health and care system should be like any operating system – the sort of thing you tend not to notice when it is working well.
- 2.3 It is, however, clear that some elements of the current legal framework need to be improved. The lessons from the pandemic cannot and should not be ignored, we need the right legislative framework to support the recovery by improving outcomes, reducing health inequalities and making best use of limited resources. Society's health and care needs are changing. People are living longer; over the next 20 years the population in England is expected to grow by almost 10%, with the number of people aged 75+ expected to grow by almost 60% - an additional 2.7 million people. New medicines and technologies are being discovered, and more of us are living with long-term conditions such as diabetes or asthma. The proportion of people aged 65+ with four or more diseases is set to almost double by 2035, with around a third of these people having a mental health problem. Covid-19 has exacerbated these trends. Our health and care system will continue to adapt and evolve, as it always has, to meet the challenges of the future and recover from the pandemic. As such, the legislative framework needs to recognise these increasingly complex needs, provide flexibility and support for the health and care system, and ultimately act as a key enabler to support and sustain the process.

**Some of the challenges we face**

- **NHS activity has grown every year since records began** (at an average of 3.3% a year). Over the last 9 years (between 2009/10 and 2018/19) the number of attendances in A&E increased by 4.3 million; the number of GP appointments have risen from 222 million in 1995 to 308 million in 2018/19; and the number of outpatient attendances has increased by almost 36 million since 2009/10.
- **Social care too has seen activity grow.** In 2019/20, there were 1.9 million requests for adult social care support from new clients, an increase of 6% since 2015/16.
- **A growing and ageing population.** Over the next 20 years the population in England is expected to grow by almost 10%. The number of people aged 75+ is expected to grow by almost 60% - an additional 2.7 million people.
- **Growing morbidity and complexity of disease.** Around 20% of our lives are spent in poor health, which has been increasing in recent years and is likely to continue in future. The proportion of people aged 65+ with four or more diseases is set to almost double by 2035, with around a third of these people having a mental health problem.
- **Medical care advancements and technological innovations.** As medical care advances there are more treatments available and more conditions can be treated.
- **Covid-19.** Covid will continue to cause innumerable short, medium and long-term effects to healthcare in the UK and has shone a spotlight on inequalities.

## Achievements

- **Improvements in health outcomes.** Life expectancy at birth in the UK is above the OECD average at 81.4. Death rates from cardiovascular disease have fallen by 60% since 1990 in England, compared to c.50% in the OECD. The UK has the 4th lowest adult diabetes prevalence rate amongst OECD countries.
- **Quality of care improvements.** As of 2020, around 94% of GP practices rated good or outstanding by the Care Quality Commission (CQC), around 82% for NHS mental health core services and 85% of adult social care providers.
- **Safety.** The UK is recognised internationally as a world-leader in driving the patient safety agenda in healthcare.
- **Covid-19 response.** As of 9 February 2021, the UK has vaccinated 12.6 million people. In the early stages of the response, the NHS COVID-19 Data Store was established, which safely brought together accurate, real-time information necessary to inform decisions in response to the current pandemic in England.

- **Building infrastructure for the future.** In October the government announced the creation of 40 hospitals and a further competition for 8 new schemes for competition by 2030.

- 2.4 A great deal of the changes required were captured in the [NHS's recommendations](#) to Government and Parliament for an NHS Bill. These described the legislative changes the NHS needed to help it to deliver the improved outcomes set out in the [NHS Long Term Plan](#). [Both these documents were published with](#) broad support in 2019.
- 2.5 Legislative change can bring real benefits when it helps to remove barriers, provide flexibility and clarify roles. That is precisely what we are seeking to do with these proposals. The measures outlined in this document are designed to make it easier for NHS organisations and their partners to work together to tackle the issues that matter most to the people they serve; to help them move from being 'importers of illness to exporters of health' to quote former Chief Medical Officer Sally Davies<sup>1</sup>. Legislation can help to create the right conditions, but it will be the hard work of the workforce and partners in local places and systems up and down the country that will make the real difference. This does not just apply to legislation for the NHS, and we have sought to develop our legislative proposals with the whole of the health and care system in mind.
- 2.6 A central theme in the NHS's own Long Term Plan is the importance of joint working with colleagues in local government and elsewhere. It is clear that neither the NHS nor local government can address all the challenges facing whole population health on their own. The ambition to reduce inequalities and support people to live longer, healthier and more independent lives will demand bold, joint and cohesive efforts. As well as closer working at a local place and system level, in some cases proportionate national legislative intervention on public health measures must play its part.
- 2.7 We also recognise that the social care system needs reform: this remains a manifesto commitment and the government intends to bring forward separate proposals on social care reform later this year. No one piece of legislation can fix all the challenges facing health and social care – nor should it try – but it will play an important role in meeting the longer-term health and social care challenges we face as a society.
- 2.8 In bringing forward these measures, we are determined to make the changes to legislation the NHS asked for and, given the government's wider responsibilities for public health and social care, we intend to take forward a set of targeted

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<sup>1</sup> Sally C Davies and Jonathan Pearson-Stuttard, *Whose Health Is It, Anyway*, pp7-8.

legislative measures to support social care, public health and safety and quality. These proposals capture the initial learning from the experience of the health and care system in responding to the pandemic and make permanent some of the innovations where Covid-19 has accelerated new and better ways of working. They provide a framework which allows further evolution and will support, harness and sustain the collaboration and integration seen during Covid-19.

- 2.9 Legislation of all kinds needs to be carefully calibrated to make only necessary and proportionate changes. The risk of legislative overreach and of an excessive specification of detail, spelling out the exact conditions under which specific organisations can and cannot work together, can lead to burdensome bureaucracy and confusion for those faced with the task of implementation. As the pandemic has shown, there is a great deal of insight, commitment and innovation in local organisations. We need a legislative framework that builds on the trust we have for those within systems to understand and deliver what their populations need.
- 2.10 Integration is a good example of this: we can legislate to make it easier to integrate care, but it is the hard work of local organisations that make integration a reality. To face the challenges facing the health and care system described above, local authorities, different parts of the NHS – hospitals, primary care, mental health teams and others – and care homes are working together more closely than ever before. In so many areas integration and coordination of services to keep people healthy and out of hospital, is already happening. Even before the pandemic, many local system leaders were seeing huge benefits from joining up across health and local authorities. The NHS and local authorities are working together to make the move from hospital to care settings more seamless for individuals. The NHS and Directors of Public Health are working together to develop more sophisticated approaches to population health management. And local organisations are working together to address the more intractable challenges associated with the wider determinants of health which are best solved when the NHS and local authorities work as a team to support an individual's physical, mental, social and economic needs. It is clear from these examples that the culture of the health and care system is changing and there is a strong recognition across organisations that joined up care and partnership working is critical to ensure better and fairer health for people in England in the years and decades ahead. We will want to engage closely with the system as we develop our implementation plans.

The road to better coordination of health and care

- 2014: NHS and local government's national leaders set out a vision of more collaboration in the NHS *Five Year Forward View*



- 2015: 'Vanguards' in 50 areas began to develop and test new models of care
- 2016: NHS and local councils formed Sustainability and Transformation Partnerships covering all of England, to consider local health and care priorities and to plan services together
- 2017: areas refined initial proposals, drawing on conversations with frontline staff, local residents and others in the community
- 2018: some partnerships began to take on more responsibility by becoming 'integrated care systems'
- 2019: NHS Long-Term Plan confirmed that every area will be served by an integrated care system by 2021, with primary and community services funded to do more
- 2020: Building on previous publications for legislative reform, NHS England set out details for how systems will accelerate collaborative ways of working in the future, considering the key components of an effective integrated care system (ICS) and reflecting what a range of local leaders have said about their experiences during the last two years, including the immediate and long-term challenges presented by the Covid-19 pandemic
- 2021: NHS England response to the ICS consultation document and the government brings forward legislative proposals to support integration

2.11 Our proposals will help to create a new framework that builds on the changes already made by the health and care system itself and which will better enable the system to tackle the challenges of the future. Beyond the legislative proposals set out in this document, there are several other ongoing developments and changes to the health and care system – including the development of a data strategy for health and social care, which will capture and build on the lessons of our COVID response and set the direction for data in a post-pandemic system, ensuring that the power of data, used properly, is able to support the transformation of care; financial arrangements to support integration and improvements to public health services – that our proposals are designed to support and to align with. An outward-looking, more connected and integrated health and care system focused on population health, public wellbeing and where technology enabled innovation is possible, and we know it is possible because it is already happening in lots of places. Our proposals are designed to enhance, support, spread and encourage the changes that are already underway to make joined up care a reality for all.

## 3. Our proposals for legislation

- 3.1 Many of the measures we are proposing have been under consideration for some time. In January 2019, the NHS published its [Long Term Plan](#) which set out the priorities for health and care over the next ten years. This plan, developed in partnership with those who know the NHS best – frontline health and social care staff, patients and their families and other experts - suggested targeted legislative proposals that would help to support the implementation of the objectives described in the Long Term Plan.
- 3.2 Following the publication of the Long Term Plan proposals for legislation, 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. There were more than 190,000 responses to this engagement exercise and in September 2019, [NHS England published their final recommendations](#). A number of influential organisations and individuals wrote to the government in broad support. These recommendations were supported in a [letter to government](#), including NHS Providers, Unison, the Local Government Association, the Academy of Medical Royal Colleges, National Voices and others.
- 3.3 NHS England’s proposals form the foundation of this Bill. Their recommendations for legislation were designed around three important principles that still stand today: any legislation should solve practical problems; avoid a disruptive top down reorganisation; and have broad consensus within the system. The majority of our proposals either directly implement or build upon NHS England’s recommendations. Where we have built upon NHS England’s proposals this is because we have explored some developments since the original NHS England publication and the experience of Covid-19 suggests there is a case to go further to reach our objective.
- 3.4 In light of this experience of dealing with the pandemic, we have also added some additional proposals in a number of key areas that fall within the broader remit of the Secretary of State for Health and Social Care. These proposals relate to public health, social care and quality and safety matters. These proposals are not intended to add up to a coherent reform package in themselves, rather they represent a specific set of proposals where change to primary legislation is required. But they are intended to complement a much wider package of reforms in social care, public health and mental health. Whilst the majority of these proposals are England only, in some case they would apply to the Devolved Administrations (DAs). We will continue to engage with DAs on all the proposals in this paper. As stated above, it is important that this legislation responds to the NHS’s asks of government, but it is also important that the legislation looks beyond just the NHS, to the whole health and care system, to ensure that

together, the system can deliver improved outcomes for the people who rely on it. Whilst this legislation is not the vehicle for wholesale social care or public health reform, we have sought to use it to address specific problems, where legislative change could be beneficial.

- 3.5 In forming our proposals, we have been able to draw upon the work done by NHS England as part of its Long Term Plan process and upon the insights generated by the extensive engagement that NHS England undertook in formulating its proposals. We have supplemented this with a number of further engagement conversations with stakeholders on both specific issues and on the wider lessons of both the pandemic and the more evolutionary changes experienced by the health and care system in recent years. See Annex C for a list of stakeholders that the Department has been engaging with.
- 3.6 The proposals we have developed can be grouped under the following themes: working together and supporting integration; stripping out needless bureaucracy; enhancing public confidence and accountability; and additional proposals to support social care, public health, and quality and safety. The full detail of these proposals can be found in Annex A. The first three themes directly implement or build on the proposals made by NHS England to government as part of its 2019 engagement exercise on legislative proposals. The final theme includes additional proposals that DHSC consider appropriate to bring forward in this Bill, in light of the experience of the pandemic, and the desire to support the health and care system to recover and reform.

## **Working together and supporting integration**

### **Enabling different parts of the health and care system to work together effectively, in a way that will improve outcomes and address inequalities**

Working together and supporting integration proposals:

1. Integrated Care Systems
2. Duty to Collaborate
3. Triple Aim
4. Foundation Trusts Capital Spend Limits
5. Joint committees

6. Collaborative Commissioning
7. Joint Appointments
8. Patient Choice
9. Data Sharing

- 3.7 Covid-19 has demonstrated the importance of different parts of the health and care system working together in the best interests of the public and patients. This has been something that organisations in the health and care system have been increasingly working towards over the past few years, despite the barriers in legislation which sometimes make it difficult to do so. We propose to implement NHS England's recommendations and legislate to support integration, both within the health service, and between the health service and local government, with its statutory responsibilities for public health and social care.
- 3.8 We want to legislate for **every part of England to be covered by an integrated care system (ICS)**. This builds on the work the system has been doing since the publication of the NHS Long Term Plan, and is in line with NHS England's recommendation in their recent document, formally recognising the need to bring together NHS organisations, local government and wider partners at a system level to deliver more joined up approaches to improving health and care outcomes, coterminous with local authorities.
- 3.9 We intend to establish a statutory ICS in each ICS area. These will be made up of an ICS NHS Body and a separate ICS Health and Care Partnership, bringing together the NHS, local government and partners. The ICS NHS body will be responsible for the day to day running of the ICS, while the ICS Health and Care Partnership will bring together systems to support integration and develop a plan to address the systems' health, public health, and social care needs. Both bodies will need to draw on the experience and expertise of front-line staff across health and social care. ICSs will be accountable for outcomes of the health of the population and we are exploring ways to enhance the role of CQC in reviewing system working
- 3.10 We know from the vanguard ICSs that taking a joined-up, population focused approach means you cannot see the people that services are meant for as just units within the system – their voice and sense of what matters to them becomes really central. That focus won't come through structures alone of course but working with organisations such as Healthwatch there is a real chance to strengthen and assess patient voice at place and system levels, not just as a commentary on services but as a source of genuine co-production.

- 3.11 This will be supported by a broad **duty to collaborate** across the health and care system and a **triple aim duty** on health bodies, including ICSs, as recommended by NHS England. This will require health bodies, including ICSs, to ensure they pursue simultaneously the three aims of better health and wellbeing for everyone, better quality of health services for all individuals, and sustainable use of NHS resources. As an additional safeguard for financial sustainability, we will take a power to impose **capital spending limits on Foundation Trusts**, in line with NHS England’s recommendation. We will implement NHS England’s recommendations to **remove barriers to integration through joint committees, collaborative commissioning approaches and joint appointments**, as well as their recommendation to preserve and strengthen the right to **patient choice** within systems. We will also legislate to ensure more **effective data sharing** across the health and care system, which is critical to effective integration, and will enable the digital transformation of care pathways. Separately set out proposals relating to Adult Social Care also contribute to our ambitions in this area, including reconfirming the legal basis of the Better Care Fund, and changes to the legal functioning of the Better Care Fund, and changes to processes around discharge and assessment.
- 3.12 Further detail on our proposals for integrated care systems is set out at Annex B, encompassing both the legislative and the non-legislative arrangements we intend to put in place. This is one of the most important elements of the legislative proposals, and we have sought to understand the hopes and concerns of a range of stakeholders in framing them. We have been particularly mindful of the importance of places within systems and of the enormous potential for joint working and innovation between local government and health partners that many of the vanguard ICSs have already demonstrated, while also recognising the distinct accountabilities of NHS bodies and local government.

## Reducing bureaucracy

**Turning effective innovations and bureaucracy busting into meaningful improvements for everyone, learning from innovations during Covid-19.**

### Reducing Bureaucracy proposals:

1. Competition
2. Arranging healthcare services
3. National Tariff

#### 4. New Trusts

#### 5. Removing Local Education Training Boards (LETBs)

3.13 In line with NHS England's recommendations, we wish to build greater flexibility into the basis provided by the 2012 legislation, where the current framework fails to enhance and streamline accountability, or necessitates complex or bureaucratic workarounds and makes it difficult for the system to integrate and adapt over time as needed. Covid-19 has presented a unique opportunity and imperative to drive real change in this area, building on the innovation and cultural shift that was already underway in many places. When the pandemic struck, the NHS, the social care sector and partners were quick to cut through some of the bureaucracy that had accumulated over a number of years. Whether it was in relation to data sharing, flexible workforce deployment, decision making / governance, or integrated delivery; in many parts of the country, system leaders responded swiftly to the challenges of the pandemic. Whilst some of these changes are only appropriate as part of an emergency response, others demonstrated how new ways of working could lead to better outcomes in more normal times. We need to build on the trust that we know we can place on frontline staff and their organisations, to enable them to deliver better outcomes and experiences for people that use health and care services.

#### **Busting Bureaucracy: optimising data requests and data sharing**

The pandemic saw the suspension of certain data collection requests from government and national bodies such as NHS England, NHS Digital and the Care Quality Commission. Where data collection was vital to the pandemic response, existing powers were used to publish notices requiring health and care bodies to share data to help manage and control the spread of Covid-19 within local systems. We will build on this approach and make changes to the regulations governing the sharing of data to enable more effective use of data for the benefit of individuals and the health and care system as a whole.

3.14 The Department of Health and Social Care's paper, [Busting bureaucracy: empowering frontline staff by reducing excess bureaucracy in the health and care system in England](#), sets out the government's strategy for reducing excess bureaucracy. These actions are being taken forward through a variety of different projects, some led by the department, some by regulators and some by other bodies across the health and care system. Whilst we can do a lot to reduce bureaucracy through changing processes and culture, the Department's engagement demonstrated that a lot of bureaucracy is also generated by the legislation which in some places is no longer fit for purpose and we therefore want to use this opportunity to amend legislation to resolve these issues.

3.15 In line with the requests made by the NHS, we will use legislation to remove much of the transactional bureaucracy that has made sensible decision-making in the system harder. The NHS should be **free to make decisions on how it organises itself without the involvement of the Competition and Markets Authority (CMA)**. We will also **reform how health care services are arranged by creating a bespoke health services provider selection regime** that will give commissioners greater flexibility in how they arrange services than at present. The NHS have committed to consulting on the new regime. Where procurement processes can add value they will continue, but that will be a decision that the NHS will be able to make for itself. These changes retain a division of responsibility between strategic planning and funding decisions on the one hand, and care delivery on the other, but allow for its operation in a more joined up way. We will preserve the division between funding decisions and provisions of care. These new flexibilities will be **reinforced by changes to the tariff to enable the tariff to work more flexibly within system approaches**; and giving the Secretary of State the **power to create New Trusts to ensure alignment within an integrated system** where that is helpful. In line with the aim of reducing the need for bureaucratic workarounds, and increasing flexibility and adaptability in the system, the government is also proposing an additional measure not put forward by NHS England in their paper: the **removal of Local Education Training Boards (LETBs) from statute** to give Health Education England (HEE) more flexibility to adapt its regional operating model over time. For social care, we also proposed introducing a new legal power to make payments directly to social care providers to remove barriers in making future payments to the sector.

## Enhancing public confidence and accountability

**Ensuring that we have the right framework for national 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**

### Ensuring accountability and public confidence proposals:

1. Merging NHS England, Monitor and the NHS Trust Development Authority and Secretary of State powers of direction
2. The NHS Mandate
3. Reconfigurations intervention power
4. Arm's Length Bodies (ALB) Transfer of Functions

## 5. Removing Special Health Authorities Time Limits

## 6. Workforce Accountability

- 3.16 Both the public and Parliament rightly expect to be able to hold decision makers who oversee the health and care system to account. Our legislative proposals focus on ensuring that our accountability arrangements command public confidence, whilst also enabling systems to get on with doing their jobs and making appropriate changes to enable transformation and innovation. This means ensuring that the framework for national oversight of the NHS is fit for purpose now and into the future.
- 3.17** The original set of national NHS bodies has already altered in form and purpose, and in the proposed legislation, we intend to continue the work already undertaken to **formally bring together NHS England and NHS Improvement into a single legal organisation.**
- 3.18 The public largely see the NHS as a single organisation and as local health systems work more closely together, the same needs to happen at a national level. Recognising the evolution of NHS England, we are **also bringing forward a complementary proposal to ensure the Secretary of State for Health and Social Care has appropriate intervention powers** with respect to relevant functions of NHS England. This will support the Secretary of State, when appropriate, to make structured interventions to set clear direction, support system accountability and agility, and also enable the government to support NHS England to align its work effectively with wider priorities for health and social care. This will serve, in turn, to reinforce the accountability to Parliament of the Secretary of State and government for the NHS and the wider health and care system.
- 3.19 Furthermore, the pandemic has highlighted the need to balance national action with local autonomy. The evolution of the system in recent years has led to greater level of responsibility being held by NHS England and NHS Improvement. As Integrated Care Systems are established, we expect more of that responsibility to be held by ICSs themselves. This will be accompanied by measures to strengthen and clarify the role of government and Parliament. The Department will also have a critical role to play in overseeing the health and care system and in ensuring strong alignment and close working between public health, healthcare and social care.
- 3.20 The Department will support the independence and accountability of ICSs, and the Secretary of State for Health and Social Care will have an important role in ensuring that integration across health, public health and social care is working



effectively within these systems. This will be enabled by a **more flexible mandate for NHS England**, which will make it easier for the Secretary of State to set objectives for the body. In addition, when it comes to significant service change, some Parliamentarians have criticised the current system for a lack of accountability and timely access to decision-making for them and the people they represent. We therefore intend to include a provision to allow the Secretary of State to **intervene in local service reconfiguration changes** where required.

- 3.21 We also intend to **legislate to ensure a more agile and flexible framework for national bodies that can adapt over time**. There are no current plans to change or transfer functions of the bodies in the system (with the exception of the changes we are making to merge NHS England and NHS Improvement, and changes arising from the establishment of the National Institute for Health Protection and related reforms to the public health system). Almost half of respondents agreed to this proposal in NHS England's consultation. The government is proposing additional safeguards, which will enable further scrutiny if this power is used. The government is also proposing to bring forward measures to **remove the 3-year time limit for Special Health Authorities from legislation**. Whilst not specifically considered in NHS England's previous recommendations, it is a measure which will support a more flexible framework for national bodies and remove unnecessary limitations from the legislation.
- 3.22 Set out in more detail below, we also intend to legislate to improve accountability in the social care sector. An enhanced assurance framework will provide a greater level of oversight of the delivery of social care by local authorities. At the same time improved data collection will improve insight into the functioning of the sector.
- 3.23 Finally, we are proposing to introduce a Secretary of State duty to publish a report every Parliament which will support **greater clarity around workforce planning responsibilities**, which reflects the concerns raised by the Royal College of Nursing in response to NHS England's publication and will support the aim of greater clarity in how national bodies operate.

## Additional proposals

### Supporting social care, public health and quality and safety

#### Additional proposals:

##### Social Care

##### 1. Assurance

2. Data
3. Direct payments to providers
4. Discharge to assess
5. A standalone power for the Better Care Fund

#### Public health

6. Public Health power of direction
7. Obesity
8. Fluoridation

#### Safety and Quality

10. Health Services Safety Investigations Body (HSSIB)
11. Professional Regulation
12. Medical Examiners
13. Medicines and Healthcare products Regulatory Agency (MHRA) new national (UK wide) medicines registries
14. Hospital food standards
15. Reciprocal healthcare agreements with Rest of World countries

3.24 We have developed an additional series of targeted proposals which will improve social care, public health and quality and safety. These complement the measures we are putting in place in response to the NHS's requests to government. The proposals are not intended to form a coherent reform package in themselves (as stated above, reforms to social care and public health will be dealt with outside this Bill), but are intended to address specific problems or remove barriers to delivery, maximise opportunities for improvement, and have in some cases been informed by the experience of the pandemic.

- 3.25 On social care: we intend to bring forward proposals to reflect the themes of supporting integration, reducing bureaucracy and improved accountability in a manner that addresses the specific needs of the social care sector. We will bring forward **measures on system assurance and data**, to ensure that there are appropriate levels of oversight on the provision and commissioning of social care; a payment power, which corrects a limitation in existing legislation preventing the Secretary of State for Health and Social Care making **emergency payments directly to all social care providers**; and proposals that provide greater flexibility as to at what point assessments for care can be made. We will also create a **standalone power for the Better Care Fund**, separating it from the NHS mandate setting process.
- 3.26 On public health we will bring forward measures to: make it easier for the Secretary of State to direct NHS England to **take on specific public health functions**; help **tackle obesity by introducing further restrictions on the advertising of high fat, salt and sugar foods**; as well as a new power for ministers to alter certain **food labelling requirements**. This will ensure consumers can be supported to make more informed, healthier choices about their food and drink purchases. In addition, we will be **streamlining the process for the fluoridation of water** in England by moving the responsibilities for doing so, including consultation responsibilities, from local authorities to central government. These public health measures will complement and augment the efforts of ICSs to make real inroads in improving population health in their areas, helping to tackle inequalities and ‘level-up’ across communities.
- 3.27 On safety and quality: we will bring forward measures to **put the Healthcare Safety Investigation Branch (HSIB) on a statutory footing**; to enable us to **improve the current regulatory landscape for healthcare professionals** as needed; to **establish a statutory medical examiner system** within the NHS for the purpose of scrutinising all deaths which do not involve a coroner and increase transparency for the bereaved, and to **allow the Medicines and Healthcare products Regulatory Agency (MHRA)** to develop and maintain publicly funded and operated medicine registries so that we can provide patients and their prescribers, as well as regulators and the NHS, with the evidence they need to make evidence-based decisions. We will also be bringing forward measures to enable the Secretary of State to **set requirements in relation to hospital food**. And finally, we will take powers to **implement comprehensive reciprocal healthcare agreements with countries outside the EEA and Switzerland** (‘Rest of World countries’) – expanding our ability to support the health of our citizens when they travel abroad, subject to bilateral agreements.

## 4. Delivering for patients, citizens and local populations - supporting implementation and innovation

- 4.1 This White Paper represents a significant milestone on the journey towards achieving our objective of supporting everyone to live healthier and fulfilling lives for longer.
- 4.2 For people using the NHS regularly, our proposals will support their GP and healthcare specialists to work together to arrange treatment and interventions that either prevent illness or prevent their conditions deteriorating into acute illness. This population health approach will be informed by better data and understanding of local populations, identifying those who are at risk and who we can impact, with a view to designing a more proactive way of planning and delivering care. It will mean that social care providers can receive emergency financial support when needed to prevent instability in care for the most vulnerable people in our communities. For staff working across the NHS, public health and social care, it should mean that there are fewer bureaucratic hurdles to overcome when they are just trying to do their job. It will support hospitals, GPs, local authorities and voluntary partners to work together to plan how they will address the health needs of their populations in the years ahead, including the use of technology, so that over time the people we care for can live healthier lives for longer. And it will ensure that the quality and safety of care continues to improve, through enhanced use of data, with investigations of things that go wrong so mistakes can be learned from.

“But no one recognises more than does the Government, and certainly no one recognises more than I do, that no legislation, however wisely conceived and however efficiently embodied in an Act of Parliament, can ever give the public a great health service unless the people who administer it want to do it and are enthusiastic in doing it” – Aneurin Bevan, [1946](#)

- 4.3 However, bringing forward legislation is only part of the story. Our proposals are designed to support and accelerate positive changes within the system – its adaptability, collaborative instincts and its ability and determination to always find a way. The measure of the success of legislative change will not be the permanent casting of the system in a single form, but instead the acceleration of its ability to learn, adapt and improve. This will also require the use of non-legislative means, including having the right workforce in place; good leadership at all levels, setting out clear guidance; and getting the incentives and financial flows

right. In order to be successful, our proposals will therefore be supported by an implementation programme that recognises the importance of key non-legislative enablers in facilitating change. We will work closely with the health and care system in developing this implementation programme.

4.4 This legislation is not intended to address all the challenges faced by the health and social care system. The government is undertaking broader reforms to social care, public health and mental health which will support the system in helping people to live healthier, more independent lives for longer.

- (a) The Department recognises the significant pressures faced by the social care sector and remains committed to reform. We want to ensure that every person receives the care they need and that it is provided with the dignity they deserve. Our objectives for social care reform are to enable an affordable, high quality and sustainable adult social care system that meets people's needs, whilst supporting health and care to join up services around people. We have committed to bringing forward proposals this year but, in the meantime, our legislative proposals will embed rapid improvements made to the system as it has adapted to challenges arising from Covid-19.
- (b) Our experience of the pandemic underlines the importance of a population health approach: preventing disease, protecting people from threats to health, and supporting individuals and communities to improve their health and resilience. The government will publish in due course an update on proposals for the future design of the public health system, which will create strong foundations for the whole system to function at its best. These changes are driven by learning from the experiences of Covid-19, but more broadly by the need to ensure we have a public health system fully fit for the future. The factors which prevent poor health are shaped by many different parts of government, public services and the broader health system. So rather than containing health improvement expertise within a single organisation, driving change in the future will mean we need many different organisations to have the capability and responsibility for improving health and preventing ill health.
- (c) In January, the Department of Health and Social Care and the Ministry of Justice published Reforming the Mental Health Act, a White Paper which responds to the Independent Review of the Act, chaired by Professor Sir Simon Wessely in 2018. This forms our plan to modernise mental health legislation. There is a clear case for modernisation and change. The White Paper sets out our proposals for a substantive programme of legislative reform, taking forward the government's commitment to legislate to give people greater control over their treatment, and ensure they are treated with the dignity and respect they deserve. It also takes forward our commitment to

improve how people with a learning disability and autistic people are treated in law and reduce the reliance on specialist inpatient services for these groups. We want everyone to have the opportunity to live a full and rewarding life in their communities and an end to perpetuated detentions without appropriate therapeutic inputs.

- 4.5 These reforms are not included in our legislative proposals but are part of a wider Departmental strategy.
- 4.6 On current timeframes, and subject to Parliamentary business and successful passage, our plan is that these proposals for health and care reform will start to be implemented in 2022. We will continue to engage with stakeholders across the health and care systems, our Arm's Length Bodies and the Devolved Administrations on the detail of these proposals as they progress. We will also continue to work across government to ensure that the right systems and processes are in place that work for all, recognising the interdependencies between health and other social determinants.

## 5. Annex A: Proposals for legislation

### Working together and supporting integration proposals

- 5.1 These proposals are about enabling different parts of the health and care system to work together effectively, in a way that will improve outcomes and address inequalities. The social care measures reflecting this theme are included as part of our additional proposals.

Working together and supporting integration proposals:

1. Establishing Integrated Care Systems
2. Duty to Collaborate
3. Triple Aim
4. Power over Foundation Trusts Capital Spend Limits
5. Joint committees
6. Collaborative Commissioning
7. Joint Appointments
8. Data Sharing
9. Patient Choice

### Establishing Integrated Care Systems (ICSs) in law

- 5.2 Integrated Care Systems (ICSs) have become an increasingly familiar part of the health and care landscape in recent years. Many of the pioneer ICSs have been highly successful in bringing partners together to improve outcomes for the public, often supporting and supplementing arrangements at place level.
- 5.3 Existing ICS arrangements are based on voluntary arrangements, rather than legislative provision, and are therefore dependent on goodwill and mutual co-operation. There are also legislative constraints on the ability of organisations within an ICS to make decisions jointly. While several systems have found ways to establish effective governance models, there are some obstacles and limitations in the current legal framework which inhibit this. For example, there is no legal basis

at present for Clinical Commissioning Groups (CCGs), NHS trusts and Foundation Trusts (FTs) to form a joint committee to which functions may be delegated, with the power to make decisions on behalf of the organisations within the ICS.

- 5.4 In order for ICSs 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.
- 5.5 The legislative provisions that we propose for Integrated Care Systems reflect NHS England's recommendations for change following their recent engagement on ICSs, and are designed to provide a small set of consistent requirements for each system that the partners who make up that system can then supplement with further arrangements and agreements that suit them. The role of ICSs in supporting integration both within the NHS and between the NHS and its partners in local authorities along with further detail on the purpose and governance of Integrated Care Systems is set out at Annex B. In this section we set out the core functions of the ICS along with a number of other provisions designed to support integration across the health and care system.
- 5.6 We are proposing to establish statutory ICSs, made up of an ICS NHS Body and an ICS Health and Care Partnership (together referred to as the ICS), to strengthen the decision-making authority of the system leadership and to embed accountability for system performance into the NHS accountability structure. This dual structure recognises that there are two forms of integration which will be underpinned by the legislation: the integration within the NHS to remove some of the cumbersome barriers to collaboration and to make working together across the NHS an organising principle; and the integration between the NHS and others, principally local authorities, to deliver improved outcomes to health and wellbeing for local people.
- 5.7 The ICS NHS Body will be responsible for:
- Developing a plan to meet the health needs of the population within their defined geography;
  - Developing a capital plan for the NHS providers within their health geography;
  - Securing the provision of health services to meet the needs of the system population.
- 5.8 The ICS NHS Body will model merge some of the functions currently being fulfilled by non-statutory STPs/ICSs with the functions of a CCG. We aim to bring the allocative functions of CCGs into the ICS NHS body so that they can sit alongside



the strategic planning function that we would like the ICS to undertake. This will enhance accountability and allow the members of the ICS to develop integrated and innovative approaches to deliver strategic objectives. Our proposals would also, in line with the approach set out by NHS England, allow for the ICS NHS Body to delegate significantly to place level and to provider collaboratives. To support our ambition for ICSs to also address broader health outcomes - including through improving population health and tackling inequalities - each ICS will also be required to establish an ICS Health and Care Partnership, bringing together health, social care, public health (and potentially representatives from the wider public space where appropriate, such as social care providers or housing providers). This body will be responsible for developing a plan that addresses the wider health, public health, and social care needs of the system – the ICS NHS Body and Local Authorities will have to have regard to that plan when making decisions.

- 5.9 In practice, we recognise that ICSs will have to develop effective and legitimate decision-making processes, and we are giving ICS NHS bodies and ICS Health and Care Partnership the flexibility to develop processes and structures which work most effectively for them. We also know that we need to support staff during organisational change by minimising uncertainty and limiting employment changes. We are therefore seeking to provide stability of employment and will work with NHSE and staff representatives to manage this process.
- 5.10 A key responsibility of the ICS will be working in partnership with other local bodies, both within the health and social care system, and more widely. In order to facilitate this, we will make it easier for organisations to work closely together, for example, through our new proposals for joint committees (see below) and existing collaborative commissioning arrangements (such as s.75 of the NHS Act 2006). This joint approach to working will also be supported by the “triple aim duty” (see the proposal below).
- 5.11 The ICS will also have to work closely with local Health and Wellbeing Boards (HWB) as they have the experience as ‘place-based’ planners, and the ICS NHS Body will be required to have regard to the Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies that are being produced at HWB level (and vice-versa). ICSs will also want to think about how they can align their allocation functions with place, for example through joint committees, though we are leaving this to local determination. NHS Trusts and Foundation Trusts (FTs) will remain separate statutory bodies with their functions and duties broadly as they are in the current legislation.
- 5.12 The creation of statutory ICS NHS Bodies will also allow NHS England to have an explicit power to set a financial allocation or other financial objectives at a system

level. There will be a duty placed on the ICS NHS Body to meet the system financial objectives which require financial balance to be delivered. NHS providers within the ICS will retain their current organisational financial statutory duties. The ICS NHS Body will not have the power to direct providers, and providers' relationships with the Care Quality Commission will remain unchanged. However, these arrangements will be supplemented by a new duty to compel providers to have regard to the system financial objectives so both providers and ICS NHS Bodies are mutually invested in achieving financial control at system level.

- 5.13 We know there has been excellent progress in some areas in making a reality of integrated care. We also know that this has sometimes been in spite of the systems we ask people to work within, and that it is far from universally true that integration is proceeding in step with the needs and lives of the people we serve. We have therefore – with the help of NHS England's work following the Long Term Plan – identified several further changes to reinforce or enable integration. Details of the NHS's proposals, which we have bolstered with an additional duty to collaborate, are set out below.

## **Duty to collaborate**

- 5.14 Alongside the creation of statutory ICSs, we intend to introduce a new duty to promote collaboration across the healthcare, public health and social care system. Many existing duties on health and care organisations emphasise the role of the individual organisation and its own interests. We want to rebalance these duties to reflect the need for all health and care organisations to work collaboratively. When collaboration works well it leads to better outcomes for people, for example a successful early intervention can lead to people living independently and in their own homes for longer.
- 5.15 This proposal will place a duty to collaborate on NHS organisations (both ICSs and providers) and local authorities. This policy also provides the Secretary of State for Health and Social Care with the ability to issue guidance as to what delivery of this duty means in practice, in recognition of the fact that collaboration may look very different across different kinds of services.
- 5.16 We intend this collaboration proposal to replace two existing duties to cooperate in legislation to support our wider ICS policy, where we expect local authorities and NHS bodies to work together under one system umbrella.

## **Triple Aim**

- 5.17 To further support integration, we propose to implement NHS England's recommendation for a shared duty that requires NHS organisations that plan

services across a system (ICSs) and nationally (NHS England), and NHS providers of care (NHS Trusts and FTs) to have regard to the 'Triple Aim' of better health and wellbeing for everyone, better quality of health services for all individuals, and sustainable use of NHS resources.

- 5.18 This will support NHS bodies to continue a culture of working together in the best interest of not only their immediate service users and organisations, but of the wider population, and for the ICS as a whole, working together strategically and through its 'place'- based constituents. We hope that the Triple Aim will help align NHS bodies around a common set of objectives, thus supporting the shift towards integrated systems which have strong engagement with their communities.

### **Reserve power over Foundation Trusts Capital Spend Limit**

- 5.19 We are also planning to implement NHS England's recommendation for a reserve power to set a capital spending limit on Foundation Trusts, which will support the third aim of the Triple Aim duty, in relation to sustainable use of NHS resources.
- 5.20 Unlike NHS Trusts, which are set annual capital expenditure limits by NHS Improvement, NHS Foundation Trusts (FTs) currently have additional freedoms to borrow from commercial lenders and spend surpluses on capital projects (e.g. new buildings, equipment or IT). However, capital expenditure by FTs still counts towards DHSC's overall Capital Delegated Expenditure Limit (CDEL).
- 5.21 In recent years, given the restraint on capital expenditure and a growing maintenance backlog, the Department of Health and Social Care has had to restrict capital expenditure by Trusts and temporarily delay capital projects to ensure that it does not breach its CDEL limit. A small number of FTs have previously indicated that they could push ahead with their individual schemes and use their own capital, without full consideration of the overall impact on the ICS and on CDEL as a whole. This could mean that at ICS or national level we may have to pause other schemes which may be strategically more beneficial or clinically required. Dialogue is the first line of defence and remediation locally and nationally, but a targeted reserve power is required as a last resort to protect the system and ensure the most sustainable use of NHS resources.
- 5.22 As we embed a new capital regime where Integrated Care Systems (ICS) are allocated a system-wide capital limit, and have duties placed upon them to create a capital plan, we are seeking powers in the Bill to be able to set legally-binding Capital Departmental Expenditure Limits (CDEL) for individual, named Foundation Trusts (FTs), where they are not working effectively to prioritise capital expenditure within their ICS, and risk breaching either system or national CDEL limits.

- 5.23 This is not a general power to direct all FTs on capital spending and is not intended to erode FT autonomy, but it is designed to be used in targeted ways to support the work of ICSs.

## **Joint Committees**

- 5.24 As NHS England set out in their engagement document, legislation does not currently allow NHS providers (NHS trusts and foundation trusts) and CCGs (which will become part of ICSs) to take joint decisions, either through a joint committee or committees-in-common, or for local authorities and other providers of NHS care to be involved in such partnership arrangements. Furthermore, Foundation Trust boards and individual directors have a duty to act with a view to promoting the success of their organisation. This creates an unhelpful barrier to joint working, and 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.
- 5.25 Our ICS NHS body provisions go most of the way to increasing the ease with which providers and commissioners could establish joint working arrangements and support the effective implementation of integrated care. We consider, nonetheless, that NHS England's recommendation to allow ICSs and NHS providers to create joint committees would be a useful addition, removing unnecessary barriers to joined-up decision making.
- 5.26 We are therefore proposing to create provisions relating to the formation and governance of these joint committees and the decisions that could be appropriately delegated to them; and separately, allowing NHS providers to form their own joint committees. Both types of joint committees could include representation from other bodies such as primary care networks, GP practices, community health providers, local authorities or the voluntary sector.

## **Collaborative Commissioning**

- 5.27 We want to support the health and care system to work collaboratively and flexibly across different footprints. Many local areas have been exploring ways of working more collaboratively and are seeking to align decisions and pool budgets between CCGs and NHS England, across CCGs, and between CCGs and local authorities (LAs).
- 5.28 Existing NHS legislative mechanisms make it difficult to do this, forcing local systems 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 decision-making processes. We intend to

implement NHS England's recommendation to change the underpinning NHS legislation to remove these barriers and streamline and strengthen the governance for this type of decision-making.

5.29 These proposals will:

- Give NHS England the ability to joint commission its direct commissioning functions with more than one ICS Board, allowing services to be arranged for their combined populations.
- Allow ICSs to enter into collaborative arrangements for the exercise of functions that are delegated to them, enabling a "double-delegation".
- Allow groups of ICSs to use joint and lead commissioner arrangements to make decisions and pool funds across all their functions (and not just commissioning functions).
- Enable a greater range of delegation options for section 7A public health services, including the ability for onward delegation of the function into collaborative arrangements, such as a section 75 partnership arrangement; and
- Enable NHS England to delegate or transfer the commissioning of certain specialised services to ICSs singly or jointly, or for NHS England to jointly commission these services with ICSs if these functions are considered suitable for delegation or joint commissioning subject to certain safeguards. 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.

## **Joint Appointments**

5.30 To support closer working between actors in the health and care system, greater clarity is needed to enable joint appointments across different organisations.

5.31 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.

5.32 In line with NHS England's recommendation, we are proposing to introduce a specific power to issue guidance on joint appointments between NHS Bodies; NHS Bodies and local authorities; and NHS Bodies and Combined Authorities. This will aid the development and delivery of integrated care and will ensure that there is a clear set of criteria for organisations to consider when making joint appointments.

5.33 NHS England will need to keep the guidance under review, and if substantial changes to it are considered, they will need to consult appropriate organisations before the revision is published.

## Data Sharing

5.34 Building on the successful data sharing in response to Covid-19, we want to ensure that health and care organisations use data, when they can do so and with appropriate safeguards, for the benefit of individuals and the wider health and social care system. The forthcoming Data Strategy for Health and Care will set out a range of proposals to address structural, cultural/behavioural and legislative barriers to data sharing and a more flexible legislative framework to improve data access and interoperability, including enabling the safe sharing of data in support of individual care, population health and the effective functioning of the system. As part of this work, we are exploring where achieving these objectives may require primary legislation. This includes proposals to:

- require health and adult social care organisations to share anonymised information that they hold where such sharing would benefit the health and social care system.
- introduce powers for the Secretary of State for Health and Social Care to require data from all registered adult social care providers about all services they provide, whether funded by local authorities or privately by individuals (discussed further in the Adult Social Care proposals); and require data from private providers of health care.
- make changes to NHS Digital’s legal framework to introduce a duty on NHS Digital to have regard to the benefit to the health and social care system of sharing data that it holds when exercising its functions; and clarify the purposes for which it can use data.
- introduce a power for the Secretary of State for Health and Social Care to mandate standards for how data is collected and stored, so that data flows through the system in a usable way, and that when it is accessed/provided (for whatever purpose), it is in a standard form, both readable by, and consistently meaningful to the user/recipient.

The measures in this Bill will help NHS organisations join up, to provide better care for the public and to plan services. None of the measures here will erode the protection of personal information.

## Patient Choice

- 5.35 Integrated services provide an opportunity to offer joined up care to all and provide clear information on the choices people have in how and where their care is delivered. A patient's right to choose where and who will provide their health and care needs will be preserved and strengthened in the new system arrangements.
- 5.36 The NHS's Long-Term Plan (LTP) makes specific proposals to strengthen patient choice and control. The LTP states that the ability of patients to choose where they have their treatment remains a powerful tool for delivering improved waiting times and patient experiences of care. The LTP also states that the NHS will continue to provide patients with a wide choice of options for quick elective care, including making use of available Independent Sector capacity. The protections and rights in relation to patient choice and the Any Qualified Provider (AQP) requirements are fundamentally set out in the current legislation.
- 5.37 As part of the wider package of changes to the arrangement of healthcare services, we propose to repeal section 75 of the Health and Social Care Act 2012 Act including the Procurement, Patient Choice and Competition Regulations 2013 and replace the powers in primary legislation under which they are made with a new provider selection regime. Under the new model, bodies that arrange NHS Services as the decision-making bodies will be required to protect, promote and facilitate patient choice with respect to services or treatment. We also want to make clearer the rules, circumstances and processes around the operation of Any Qualified Provider (AQP).
- 5.38 We will take forward the NHS's recommended approach by retaining existing patient choice rights and protections and bolstering the process for AQP arrangements. In addition, ICSs can be powerful drivers of patient centred approaches that provide greater choice and control to patients by transforming services around the specific needs of their populations.
- 5.39 We will also work closely with the NHS to reduce the health inequalities currently experienced in the area of choice, by helping to increase clarity and awareness of patient choice rights within systems and of the range of choices available.

## Reducing bureaucracy proposals

- 5.40 These proposals focus on stripping out needless bureaucracy, turning effective innovations and bureaucracy busting into meaningful improvements for everyone, learning from the innovations during Covid-19.

Reducing Bureaucracy proposals:

1. Competition
2. Arranging healthcare services
3. National Tariff
4. New Trusts
5. Removing Local Education Training Boards (LETBs)

5.41 The Department's recent [Busting Bureaucracy](#) exercise showed how bureaucracy can act as a barrier to the frontline when delivering care. We want to remove those barriers and use our legislation to give people in the system the flexibility to work together to improve services for everyone. We also want to remove parts of the legislation which no longer reflect the current ways of working and have necessitated complex and often bureaucratic workarounds, and made it difficult for the system to adapt over time as needed. The social care measures reflecting this theme are included as part of our additional proposals set out below.

## Competition

5.42 Whilst competition can drive service improvement, it has in some cases hindered integration between providers. Currently, the Competition and Markets Authority (CMA) have specific powers to review mergers involving Foundation Trusts (FT). It has become clear that the CMA is not the right body to review NHS mergers. In line with NHS England's recommendations, we intend to remove these powers and allow NHS England, as overseer of the system, to ensure that decisions can always be made in the best interests of patients. The CMA's jurisdiction over mergers is UK-wide, so we are working with the devolved administrations to ensure there would be no unintended consequences of these proposals.

5.43 Building on the experience of the last few years, we now want to take forward proposals to legislate to clarify the central role of collaboration in driving performance and quality in the system, rather than competition. The proposals are to:

- Remove the CMA function to review mergers involving NHS foundation trusts. The CMA's jurisdiction in relation to transactions involving non-NHS bodies (e.g. between an NHS Trust/FT and private enterprise) and other health matters (e.g. drug pricing) would be unchanged.
- Remove NHS Improvement's specific competition functions and its general duty to prevent anti-competitive behaviour.



- Remove the need for NHS England to refer contested licence conditions or National Tariff provisions to the CMA.

5.44 Alongside the role of competition in driving service improvement, it is also right that (as the newly merged body) NHS England's main role is on supporting improvements in health outcomes, the quality of care and use of NHS resources.

## **Arranging healthcare services**

5.45 The NHS has sent us a clear message that the current regime for arranging healthcare services is not working. It is confusing, overly bureaucratic and does not support the integration and efficient arrangement of services in the best interest of patients.

5.46 In line with the requests made by NHS England, which garnered strong support from the wider system, we will use legislation to remove much of the transactional bureaucracy that has made sensible decision-making and collaboration in the system harder. We will reform the approach to arranging healthcare services and create a bespoke regime that will give commissioners more discretion over when to use procurement processes to arrange services than at present, with proportionate checks and balances. Where competitive processes can add value they should continue, but that will be a decision that the NHS will be able to make for itself.

5.47 The reforms within these legislative proposals will remove the current procurement rules which apply for NHS and public health commissioners when arranging healthcare services. They will do this by creating the powers to remove the commissioning of these services from the scope of the Public Contracts Regulations 2015, as well as repealing Section 75 of the Health and Social Care Act 2012 and the Procurement, Patient Choice and Competition Regulations 2013.

5.48 The powers within the Bill are intended to enable us to develop a new provider selection regime which will provide a framework for NHS bodies and local authorities to follow when deciding who should provide healthcare services. The provider selection regime will be informed by NHS England's public consultation , and aims to enable collaboration and collective decision-making, recognising that competition is not the only way of driving service improvement, reduce bureaucracy on commissioners and providers alike, and eliminate the need for competitive tendering where it adds limited or no value. Commissioners will be under duties to act in the best interests of patients, taxpayers, and the local population when making decisions about arranging healthcare services.

- 5.49 We anticipate that there will continue to be an important role for voluntary and independent sector providers, but we want to ensure that, where there is no value in running a competitive procurement process, services can be arranged with the most appropriate provider. The NHS will continue to be free at the point of care and our proposals seek to ensure that where a service can only be provided by an NHS provider e.g. A&E provision, that this process is as streamlined as possible.
- 5.50 These reforms will only apply to the arrangement of healthcare services – including public health services whether commissioned solely by a local authority or jointly by the local authority and NHS as part of a S75 agreement. The procurement of non-clinical services, such as professional services or clinical consumables, will remain subject to Cabinet Office public procurement rules.

## **National Tariff**

- 5.51 The legislation for the National Tariff allows a substantial degree of flexibility, in what is a complex area – but it was in part designed to further implement a system of ‘payment by results’ or payment by activity, as part of the wider 2012 Act reforms, and in some respects its provisions may not always best facilitate new payment approaches to support collaboration or support the use of digital tech and services in the provision of care. As we move towards a system of ICSs focused on population health, we want to ensure that the payment system supports that direction of travel.
- 5.52 The set of proposals relating to the National Tariff are intended to implement NHS England’s recommendations and 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. Experiences during the pandemic have also demonstrated the positive impact that financial frameworks can have on facilitating joint working.
- 5.53 We will take forward NHS England’s proposals on the National Tariff, by amending the legislation to enable the National Tariff to support the right financial framework for integration whilst maintaining the financial rigour and benchmarking that tariff offers. This includes:
- Where NHS England specifies a service in the National Tariff, then the national price set for that service may be either a fixed amount or a price described as a formula.
  - NHS England could amend one or more provisions of the National Tariff during the period which it has effect, with appropriate safeguards.

- Remove the requirement for providers to apply to NHS Improvement for local modifications to tariff prices.
- NHS England should be able to include provisions in the National Tariff on pricing of NHS public health services where exercising public health functions delegated by the Secretary of State.

## **New Trusts**

- 5.54 We are not seeking to significantly alter the provider landscape; however, NHS England's recommendations to government included a provision to allow the creation of new trusts for the purposes of providing integrated care. We agree that there may be merit in creating a new trust to provide integrated care, and there may also be other circumstances when the Secretary of State may want to create a new trust. Consequently, we intend to allow the creation of new NHS trusts with the overriding objective of ensuring the health system is structured to deliver the best outcomes for whole population health and respond to emerging priorities. This is in line with our overarching aim to ensure the system is flexible and adaptable into the future, and wherever possible avoids the need for complex workarounds to deliver system priorities.
- 5.55 We are therefore bringing forward measures that will enable ICSs to apply to the Secretary of State to create a new trust. Any new trust will be subject to appropriate engagement and consultation. This process will be set out in guidance.

## **Removing Local Education Training Boards (LETBs)**

- 5.56 The collaborative working between Health Education England (HEE), NHS England and NHS Improvement and the Department on the development of the [NHS People Plan](#) has shown the need for a flexible and future-proofed regional workforce operating model.
- 5.57 In light of this work, we have reviewed the role of Local Education and Training Boards. These were originally established in 2012 as statutory sub-committees of HEE to perform HEE's functions at local and regional level by ensuring effective regional planning systems for the planning and delivery of education and training. In addition, LETBs had a direct role in commissioning the education and training required at local level, a role which has diminished following the 2017 education funding reforms. However, LETB functions are restricted by legislation which has limited their scope to adapt and interact with the regional directorates of NHS England and Improvement and the newly established non-statutory Regional

Workforce and People Boards (which now provide an architecture consistently across England for oversight of Workforce, Education and Training).

- 5.58 We are proposing to amend the Care Act 2014 (which sets out the functions and constitution of HEE and LETBs) to remove LETBs from statute. We believe removing LETBs from statute with their functions continuing to be undertaken by HEE (and reporting to the HEE Board) will provide HEE with the flexibility to adapt its regional operating model over time. Accompanied with our proposal for the Secretary of State for Health and Social Care to take a statutory duty to publish a document outlining the workforce planning and supply system at national, regional and local level, this measure will provide clarity over responsibilities.
- 5.59 While LETBs operate only in England, we will work with devolved administrations should this proposal have any UK-wide impact.
- 5.60 This proposal was not directly recommended by NHS England, but it flows as a consequence of the changes being recommended by NHS England to encourage more system working, and fits with our plans to ensure the legislative framework is not overly rigid or restrictive, and can adapt over time as needed.

## **Ensuring accountability and enhancing public confidence proposals**

- 5.61 These proposals focus on enhancing public confidence by ensuring that we have the right framework 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.

### Ensuring accountability and enhancing public confidence proposals

1. Merging NHS England, Monitor and the NHS Trust Development Authority and Secretary of State powers of direction
2. The NHS Mandate
3. Reconfigurations intervention power
4. Arm's Length Bodies (ALB) Transfer of Functions
5. Removing Special Health Authorities Time Limits
6. Workforce Accountability

## **Merging NHS England, Monitor and NHS Trust Development Authority and Secretary of State powers of direction**

- 5.62 In their recommendations to Government, NHS England recommended that NHS England and NHS Improvement should be permitted to merge fully, as requested by both their boards and strongly supported in the engagement responses.
- 5.63 As NHS Improvement currently consists of the NHS Trust Development Authority (NHS TDA) and Monitor, we are proposing to formally transfer their functions to NHS England and abolish Monitor and the NHS TDA.
- 5.64 Over the last two years, we have seen NHS England and NHS Improvement come together to work effectively as a single organisation. We have seen clear benefits from them working in practice as one organisation providing national leadership: speaking with one voice, setting clearer and more consistent expectations for providers, commissioners and local health systems; removing unnecessary duplication; using collective resources more efficiently and effectively to support local health systems and ultimately making better use of public money.
- 5.65 Despite the success of NHS England and NHS Improvement's joint working programme, there are limits to how far they can fully collaborate under the current legislation. For example, both organisations have separately been assigned some distinctive and non-shareable functions in legislation – they are currently required to have separate Boards, Chairs, CEOs and non-executive directors and still consist of three separate employers. Despite the efforts of both organisations to find practical arrangements and 'work-arounds', these restrictions and governance arrangements prevent the organisations from fully operating as one single organisation.
- 5.66 The public largely see the NHS as single organization and as local health systems work more closely together, the same needs to happen at a national level.
- 5.67 By bringing forward this proposal to formally bring NHS England and NHS Improvement together, we will remove these remaining bureaucratic and legislative barriers, enabling the organisation to legally come together as one to provide unified national leadership for the NHS.
- 5.68 As a newly public merged body, NHS England will, of course, remain answerable to the Secretary of State for Health and Social Care and Parliament for all aspects of NHS performance, finance and care transformation. However, the NHS England of 2022 will combine NHS England itself with Monitor and the NHS Trust

Development Authority, each of which currently have different accountabilities. Recognising this evolution, we are bringing forward a complementary proposal to ensure the Secretary of State has appropriate intervention powers with respect to NHS England. This will maintain clinical and day to day operational independence for the NHS but will support accountability by allowing the Secretary of State for Health and Social Care to formally direct NHS England in relation to relevant functions. This will support system accountability and agility, and also enable the Government to support NHS England to align its work effectively with wider priorities for health and social care. This will serve, in turn, to reinforce the accountability of the Secretary of State and Government for the NHS and the wider health and care system.

- 5.69 The public and patients need to know that when issues arise, and when people need answers to their concerns, there are systems in place to address the issues at the appropriate level. That is likely to almost always be done within systems rather than at a national level. However, there will be occasions when it will be necessary for national leadership and for NHS England to set direction. Equally, there will be occasions when it is appropriate for ministers to take more oversight in relation to NHS England, and these proposed powers would structure such interventions and ensure Ministers are accountable for them.
- 5.70 It will also support the Secretary of State to set clear direction in a more agile way, and to do so formally alongside the strong and effective informal arrangements for working together that have evolved between the Department and NHS England in recent years.
- 5.71 These powers will not allow Secretary of State to direct local NHS organisations directly nor will they allow the Secretary of State to intervene in individual clinical decisions. They will also not undermine the established NICE process and guidance for treatments and medicines.

## **The NHS Mandate**

- 5.72 Each year the Government publishes the NHS mandate, a document which sets out the objectives which NHS England should seek to achieve. The NHS mandate is intended to set strategic direction for the NHS by setting out the top priorities that the Government expects NHS England to focus on delivering. These objectives are carried through to NHS England's planning guidance.
- 5.73 When NHS England, Monitor and the NHS Trust Development Authority are legally merged, the current statutory mandate to NHS England will cover the whole of the combined organisation.

- 5.74 At present, the process for setting, publishing and replacing the mandate is linked to the financial cycle and takes place annually. Before the start of each financial year, the Secretary of State for Health and Social Care must publish and lay before Parliament the NHS mandate. However, this annual cycle has become problematic as it does not align with timescales for other strategic decisions that should influence and align with the mandate's content. For example, by the time the mandate is published alongside the new financial year, the NHS has completed its annual planning round and local organisations have signed off plans for the coming year.
- 5.75 To allow the mandate to set direction over a longer term and in a more strategic way than currently permitted by the annual cycle, we are proposing to replace the current legislative requirement to have a new mandate each year with a new requirement to always have a mandate in place. It will also provide the flexibility for the mandate to be replaced to respond to changing strategic needs, emerging evidence on deliverability or appropriateness of objectives, or external events, rather than having to wait until the next annual opportunity.
- 5.76 This proposal will remove the duty to set NHS England's capital and revenue resource limits in the mandate itself. Instead, these limits will continue to be set within the annual financial directions that are routinely published, and which will, in future, also be laid in Parliament. The direction set in the mandate will continue to be closely aligned to the capital and resource spending limits set through financial directions. The Secretary of State will retain their duty to consult NHS England before setting a mandate.
- 5.77 Additional consequential changes will also be made to the current legal provisions on integration (the Better Care Fund) which currently rely on the NHS mandate. These provisions will be recreated as a standalone power so that they will continue to meet the policy intention for the Better Care Fund even where mandates are not replaced annually.
- 5.78 This proposal will not impact on Parliament's ability to scrutinise the mandate – each new mandate will continue to be laid in Parliament by the Secretary of State and will be published. NHS mandate requirements will also continue to be underpinned by negative resolution regulations, providing further opportunity for Parliament to engage with the content of the mandate. Furthermore, the existing duty for the Secretary of State to consult NHS England, Healthwatch England, and any other persons they consider appropriate before setting objectives in a mandate, will also remain in place. Healthwatch England's involvement ensures that all NHS mandates are informed by the needs of patients and the public.

## Reconfigurations intervention power

- 5.79 Reconfigurations involve changing the way NHS services are delivered to patients, such as the closure of several stroke units being replaced with a single centralised hyper acute unit.
- 5.80 Most service changes happen locally by consent – planned reconfigurations are developed at local or regional levels by commissioners. The current system for reconfigurations works well for most service changes, and so this will remain in place for the majority of day-to-day transactions.
- 5.81 Where it does not work well, however, is in cases which are a significant cause for public concern or are particularly complex. Inevitably some can be more controversial and can lead to difficult – even intractable – debate and processes that stretch on for years.
- 5.82 The Secretary of State is currently only able to intervene in such cases upon receiving a local authority referral and may commission the Independent Reconfiguration Panel to provide recommendations. After receiving these, the Secretary of State will communicate his final decision. Whilst this can help with difficult cases, referrals can often come very late in the process. This can lead to difficult debates and lengthy processes, meaning a long and arduous journey to a decision being made and local areas and their democratic representatives are left in limbo. This leaves ministers in the position of having to account for service changes in Parliament without having been meaningfully engaged on them themselves. In the context of Covid-19, the situation on reconfigurations (especially temporary ones) is integral to understanding both system resilience and the strengths and weaknesses of recovery plans.
- 5.83 We are therefore proposing to broaden the scope for potential ministerial intervention in reconfigurations, creating a clear line of accountability, by allowing the Secretary of State to intervene at any point of the reconfiguration process. The Secretary of State will be required to seek appropriate advice in advance of their decision, including in relation to value for money, and subsequently publish it in a transparent manner.
- 5.84 To support this intervention power, we will introduce a new process for reconfiguration that will enable the Secretary of State to intervene earlier and enable speedier local decision-making. We will issue statutory guidance on how this process will work as well as removing the current local authority referral process to avoid creating any conflicts of interest. We will publish further details of proposed arrangements in due course. This would mean that we expect the Independent Reconfiguration Panel to be replaced by new arrangements. Since its establishment in 2003, the Independent Reconfiguration Panel has provided



advice to the Secretary of State on over 80 cases and we will learn from the work of the IRP as we develop processes that build on lessons and principles for achieving successful service change.

- 5.85 We do not anticipate this power being used with great frequency but where there are issues that Ministers have concluded need to be pressed to a resolution, this will provide a means of doing so.

## **Arm's Length Bodies (ALB) Transfer of Functions Power**

- 5.86 Looking beyond just NHS England, to the wider national landscape, we have seen the Department's Arm's Length Bodies, with all their differing functions and operations, respond rapidly to the Covid-19 pandemic and demonstrating immense flexibility. From the outset, core activities were streamlined whilst new Covid-19 related work programs were implemented. We have seen our ALBs working more closely together in collaborative ways in order to support and improve people's health and care.
- 5.87 It is important that when needed, we can support our ALBs to work flexibly, make it easier for them to respond to future challenges, and provide clarity about who is responsible and accountable for various functions. Therefore, we are proposing to create a power in primary legislation for the Secretary of State for Health and Social Care to transfer functions to and from specified ALBs. This mechanism will allow us to review where functions are best delivered in order to support a more flexible, adaptive and responsive system. In cases where an ALB becomes redundant as a result of transfer of its functions, this power will also include the ability to abolish that ALB. The power to transfer functions and the power to abolish an ALB will be only be exercisable via a Statutory Instrument (SI), following formal consultation. Devolved administrations will also be consulted from the outset so that provision can be made for their approval of any transfer of functions that are operative within their nations.
- 5.88 In the responses to NHS England's engagement exercise, stakeholders sought further detail and clarity about how the power could be used. 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 (as we have seen between NHS England and NHS Improvement, for example).
- 5.89 There is no immediate plan to use this power. Use of this power will be subject to a full, open and transparent process throughout. Before it can be used, a formal consultation will be required. The Secretary of State will also need to consider any

recommendations made by Parliamentary Committees, and both Houses of Parliament would need to approve the proposal. This process will ensure that the ALBs, the wider health and care system, and Parliament will have the opportunity to scrutinise any plans for its use, and to ensure that any movement of functions is right for the health and care system and the public.

## **Special Health Authorities Time Limits**

- 5.90 We greatly value our Special Health Authorities (SpHAs) and the work that they do. There are currently five SpHAs, each with their own distinct and important roles. These are the NHS Business Services Authority (NHSBSA), the NHS Trust Development Authority (TDA), NHS Blood and Transplant (NHSBT), NHS Resolution (NHSR) and the NHS Counter Fraud Authority (NHSCFA).
- 5.91 Currently, existing legislation sets an automatic expiry date on SpHAs set up after 2012, which requires us to formally extend their existence every three years. This is a time consuming and bureaucratic process that creates unnecessary administration costs for the SpHAs and the department.
- 5.92 This proposal will remove the three-year time limit on all SpHAs. Not only is this time limit unnecessary as the functions of the SpHAs are enduring, it is also inconsistent as the time limits only currently impact one SpHA, the Counter Fraud Authority (CFA); and any future SpHAs that come into being would also be subject to the time limit legislation. By removing this time limit, we are ensuring all SpHAs are treated equally in legislation and removing the bureaucratic, time consuming and duplicative process.

## **Workforce Accountability**

- 5.93 The Department is proposing to create a duty for the Secretary of State for Health and Social Care to publish a document, once every five years, which sets out roles and responsibilities for workforce planning and supply in England. This document would:
- cover the NHS including primary, secondary, community care and where sections of the workforce are shared between health and social care e.g. registered nurses, and health and public health e.g. doctors and other regulated healthcare professions.
  - describe the workforce planning and supply system including the roles of DHSC and its Arm's Length Bodies, NHS bodies and others and how they work together.
  - not give any bodies additional functions to those they already have in statute,

- be co-produced with (at a minimum) Health Education England and NHS England.

5.94 The purpose of this document is to set out in one document the current roles and responsibilities in order to provide greater transparency.

## **Additional proposals**

5.95 The remaining proposals are designed to support social care, public health and safety and quality.

### Social care

1. Data
2. Assurance
3. Direct payments to providers
4. Discharge to assess
5. A standalone power for the Better Care Fund

### Public health

6. Public Health power of direction
7. Obesity
8. Fluoridation

### Safety and Quality

9. Health Services Safety Investigations Body (HSSIB)
10. Professional Regulation
11. Medical Examiners
12. Medicines and Healthcare products Regulatory Agency (MHRA) new national (UK-wide) medicines registries
13. Hospital food standards
14. Reciprocal healthcare agreements with Rest of World countries

## **Social Care**

- 5.96 We are proposing a number of specific and targeted social care changes which address the key themes of the Bill. Our proposed legislative measures encourage joined up care for everyone by ensuring local government and social care stakeholders are at the heart of our ICS proposals, and by amending the legal framework to enable person-centred approaches to hospital discharge. A new power for the Secretary of State to make payments directly to adult social care providers, will remove a bureaucratic barrier to delivering support to the sector in exceptional circumstances like those we have seen in the last year. Finally, we want to increase accountability in the delivery of social care through an enhanced assurance framework examining the performance of local authorities, and a new power to collect data from providers.
- 5.97 These measures embed improvements that have been made to the system as it has adapted to address needs arising from Covid 19. They will grant us a greater ability to respond flexibly to the needs of the sector while adapting and developing existing practice in a way that does not place undue burden on local authorities or social care providers. The Bill will also serve as a platform for detailed policy design in collaboration with stakeholders as we move forward on wider reforms for the sector.
- 5.98 The legislative measures in the Bill are just one element of a wider programme of positive reform for the adult social care sector. We remain committed to sustainable improvement of the adult social care system and will bring forward wider social care reform, with proposals to be published this year.

## **Integrated Care Systems and Adult Social Care (ASC)**

- 5.99 ICS legislation will complement and reinvigorate place-based structures for integration between the NHS and Social Care, such as Health and Well-Being Boards, the Better Care Fund and pooled budget arrangements. The ICS Health and Care Partnership will be a springboard for bringing together health, local authorities and partners, to address the health, social care, and public health needs at a system level, and to support closer integration and collaborative working between health and social care. We will support this by published guidance that will offer support for how ICS Health and Care Partnerships can be used to align operating practices and culture with the legislative framework to ensure ICSs deliver for the ASC sector.
- 5.100 We will also create a more clearly defined role for Social Care within the structure of an Integrated Care System NHS Board. This will give ASC a greater voice in NHS planning and allocation.

- 5.101 We also recognise the importance of bringing together ICSs and Health and Wellbeing Boards (HWB) as complimentary bodies at system and place level. ICS NHS Bodies and Health and Care Partnerships will have formal duties to have regard to HWB plans, and we will continue to support and prioritise meaningful integration that makes patient and user journey's smoother.
- 5.102 Putting ICSs on a statutory basis will also act as a foundation for future work to shape ICSs as they develop, to ensure that they effectively promote integration between health and care at place level, as well as improving integration within the NHS. The active involvement of the sector in this work going forwards will be hugely important in ensuring that ICSs deliver for adult social care.

### **Improve the quality and availability of data across the Health and Social Care Sector**

- 5.103 We need to make changes to the data we collect and the frequency with which we collect it; not just for central government assurance and oversight, (further detail is provided on this below), but so that local authorities, providers and consumers can access the data they need, while minimising the burden on data providers. Building on improvements made by existing tools such as the capacity tracker implemented during the pandemic and an increased ability to gather data from social care providers (for both local authority and privately funded care), we will remedy gaps in available data to help us understand capacity and risk in the system. This will enable the Department to better understand the system to inform future policy developments and ultimately help facilitate the care of individuals across the care system. Unlike the NHS, adult social care is not one national system. Many bodies currently collect information but there is little standardisation in how data are collated, shared and used. Data should flow better to cover the whole sector, and this represents a first step towards development of a more integrated data system.
- 5.104 One such gap in our existing data from local authorities is around services provided to those who self-fund their care. By collecting data from social care providers on the services they offer we will be able to better understand this aspect of the system. Data on hours of care services provided and their cost per person, together with data on financial flows, will show how money flows to providers and workforce. With client level data, we can make links with health data and use it to improve our understanding of the lifetime cost of care. This will also support improved cooperation and joint decision-making between health and social care partners in delivering shared outcomes.
- 5.105 With more and better data, we can plan the future care of our population and will have the potential to generate significant health benefits such as increased independence, improved quality of care, higher patient satisfaction and more

efficient use of funding. Improved data on the sector workforce can also benefit recruitment, retention and equality policies.

- 5.106 We want high quality data, collected to agreed high standards and that meets the needs of all users. Through technology and data strategies, and through the Data Alliance Partnership, we are working to ensure the most efficient methods of data collection, improvement in the interoperability of systems will mean that data will be able to be collected through provider systems, reducing reporting burdens by extracting from existing data sets and sharing with multiple users. By maximising the use of technology and using data intelligently, we will support commissioning and delivery of high-quality services.

### **A new assurance framework for social care**

- 5.107 Demographic change has resulted in more people turning to social care and we expect this trend to continue for the foreseeable future. Local authorities are at the forefront of our response to this challenge, and we welcome their commitment to providing high quality outcomes as envisaged through the Care Act 2014, placing an emphasis on personalisation, choice and early intervention.
- 5.108 As social care affects a greater number of people at some point during their lives, accountability for services becomes increasingly important for both national and local government. It is therefore only reasonable for Government to want to ensure the ASC system is delivering the right kind of care, and the best outcomes, with the resources available. We also want to be able to readily identify best practice across the system, building on existing sector-led support and improvement programmes. To achieve this, we want to work with local authorities and the sector to enhance existing assurance frameworks that will support our drive to improve the outcomes and experience of people and their families in accessing high quality care and support, regardless of where they live. To support these goals, we propose to introduce through the Health and Care Bill, a new duty for the Care Quality Commission to assess local authorities' delivery of their adult social care duties. Linked to this new duty we also propose to introduce a power for the Secretary of State to intervene where, following assessment under the new CQC duty, it is considered that a local authority is failing to meet their duties. Any intervention by the Secretary of State would be proportionate to the issues identified and taken as a final step in exceptional circumstances when help and support options have been exhausted. Our plan is to secure these provisions in primary legislation at a high-level, prior to working with government partners and the sector on detailed system design and practice, providing a long-term basis of consistent oversight with the goal of reducing variation in the quality of care.
- 5.109 We understand that these proposals come following an extraordinarily challenging year for adult social care, which is why our initial focus will be to improve the

quality, timeliness and accessibility of adult social care data, with the assessment and intervention elements to be introduced over time as the final element of the assurance framework.

### **Provide a power for the Secretary of State for Health and Social Care to make payments directly to providers**

- 5.110 The Coronavirus pandemic has demonstrated the need for speed and flexibility in providing support to the social care sector. Coronavirus has also clearly demonstrated how unforeseen and quickly changing circumstances may require fast intervention. We are therefore legislating to amend the Health and Social Care Act 2008 to expand the powers of the Secretary of State for Health and Social Care, which currently allows the Secretary of State to make payments to not-for-profit bodies engaged in the provision of health or social care services in England. The Bill will widen this to allow direct payments to be made to any bodies which are engaged in the provision of social care services in England.
- 5.111 The Bill will not prescribe in what circumstances the power can be used, or how it should be provided. Instead, this power will act as a legal foundation for future policy proposals.
- 5.112 The type of payment will be determined on a case-by-case basis. However, we are clear that this power will not be used to amend or replace the existing system of funding adult social care, where funding for state provision is provided via local authorities, largely through local income, and supplemented by government grant funding. Instead, it will only be used in exceptional circumstances.

### **Discharge to assess**

- 5.113 We will bring forward measures to update approaches to hospital discharge to help facilitate smooth discharge, by putting in place a legal framework for a 'Discharge to Assess' model, whereby NHS continuing healthcare (CHC) and NHS Funded Nursing Care (FNC) assessments, and Care Act assessments, can take place after an individual has been discharged from acute care. This will replace the existing legal requirement for all assessments to take place prior to discharge.
- 5.114 This change will help to embed good practice guidelines which have been followed over the past few years. Providing a legal framework for this model allows for the safe discharge of individuals into an environment familiar to them, enabling a more appropriate and accurate evaluation of an individual's care and support needs. Discharge to Assess will not change the thresholds of eligibility for CHC or support through the Care Act or increase financial burdens on local authorities.

5.115 As a requirement to assess prior to discharge is removed, the system of discharge notices, and associated financial penalties, will no longer be required, and will also be removed by this legislation.

### **A standalone power for the Better Care Fund**

- 5.116 As set out above, legislation will be amending the process for setting the NHS mandate so that it is no longer set on a rolling annual basis. Currently the allocation of the Better Care fund is tied to this annual process. As such, we will be creating a standalone legislative power to support the Better Care Fund and separate it from the mandate setting process.
- 5.117 This will be a technical change, and will not have any impact on the function, purpose or policy intention for the fund.

### **Proposals relating to public health**

- 5.118 Alongside the Government's proposals for the future design of the public health system, including the creation of the National Institute for Health Protection (NIHP) and the closure of Public Health England, we are bringing forward a range of targeted proposals in primary legislation relating to public health. Taken together, the proposals will strengthen local public health systems, improve joint working on population health through ICSs, reinforce the role of local authorities as champions of health in local communities, strengthen the NHS's public health responsibilities, strengthen the role of the Department of Health and Social Care in health improvement, and drive more joint working across government on prevention.
- 5.119 We are also taking measures to intervene in one of the biggest health problems this country faces: obesity; recognising that there is an opportunity to help people make better informed food choices and to help them improve their health.
- 5.120 Fluoride is a naturally occurring substance that has been shown to improve oral health. We will work to streamline the process for initiating proposals for new schemes for fluoridation of water in England by moving the responsibilities for doing so from local authorities to central government.

### **Public Health power of direction**

- 5.121 Under existing legislation in section 7A of the 2006 Act, the Secretary of State for Health and Social Care can make arrangements for his public health functions to be exercised by other bodies including NHS England. Currently, this delegation is made by agreement by way of the ['NHS Public Health Functions Agreement'](#) which is made annually between the Secretary of State and NHS England for



commissioning a range of public health services, often referred to as 'section 7A services'.

- 5.122 Under this agreement, NHS England currently commissions a range of services which include national immunisation programmes; national population screening programmes; child health information services; public health services for adults and children in secure and detained settings in England; and sexual assault services (sexual assault referral centres).
- 5.123 The annual NHS Public Health Functions Agreement process is seen as a helpful mechanism for collaborative working; adding value to the health service and providing a framework for delegating delivery of key programmes. However, the Secretary of State cannot require NHS England to take the delegated function. This limits his options to deliver better care and value for patients and the taxpayer in a timely manner.
- 5.124 As such, our proposal is to create a power for the Secretary of State for Health and Social Care to require NHS England to discharge public health functions delegated by the Secretary of State alongside the existing section 7A provisions (which will be retained as they have application to a wider range of bodies and, in general, are an effective mechanism in most circumstances).
- 5.125 In common with the proposed power of direction in respect of NHS England's other functions, this includes scope to direct as to how those delegated functions are to be exercised.
- 5.126 During the pandemic we have seen the increased need to ensure join up between our NHS and public health sectors. By having this power, we will enhance the ability to facilitate urgent updates or rapid service change when needed.

## **Obesity**

- 5.127 Obesity is one of the biggest health problems this country faces. The number of children admitted to hospital for obesity and related conditions has quadrupled in the last decade. Individuals who are obese in their early years are more likely to become obese adults, putting them at a higher risk of ill-health, such as heart disease, type 2 diabetes, several types of cancer and fatty liver disease, and premature death. Evidence also shows that people living with obesity are significantly more likely to become seriously ill and be admitted to intensive care with Covid-19 compared to those with a healthy weight. The need to act now and tackle obesity is clear.
- 5.128 Building on the Government's obesity strategy, [Tackling obesity: empowering adults and children to live healthier lives](#), we want to help people make better

informed food choices and to help them improve their own health. We are making several changes to legislation to support the government's ambitions to halve childhood obesity by 2030, to reduce the number of adults living with obesity and to reduce health inequalities.

- 5.129 We are proposing to amend section 16 of the Food Safety Act 1990 to give ministers the power to amend the EU Food Information to Consumers (2011/1169) regulations that have been transposed into UK law. This will allow ministers to introduce new strengthened labelling requirements that best meet the needs of the consumer to make more informed, healthier choices subject to approval by Parliament.
- 5.130 This power will enable the swift introduction of key obesity strategy policies such as changes to our front-of-pack nutrition labelling scheme and mandatory alcohol calorie labelling, following consultation. We are considering the impact of this clause with the devolved administrations and will continue to engage them on our current and any future policy proposals.
- 5.131 It is the government's intention to introduce further advertising restrictions to prohibit advertisements for products high in fat, sugar or salt (HFSS) being shown on TV before 9pm. In November and December 2020, we consulted on how to go further and implement an online restriction for HFSS advertisements. Depending on the outcome of this consultation, it is our intention to take forward further online advertising restrictions simultaneously in this legislation.

## **Water Fluoridation**

- 5.132 Water Fluoridation is clinically proven to improve oral health and reduce oral health inequalities. It has a protective effect which reduces the impact of a high sugar diet or poor oral hygiene. Around 10% of the population of England currently receive fluoridated water. In the most deprived areas fluoridation of water has been shown to reduce tooth decay in 5-year olds by a third.
- 5.133 Since 2013, local authorities have had the power to propose, and consult on, new fluoridation schemes, variations to existing schemes, and to terminate existing schemes. The Secretary of State for Health and Social Care has responsibility for approving any proposals submitted by local authorities. Local authorities have reported several difficulties with this process including the fact that local authority boundaries are not co-terminous with water flows, which requires the involvement of several authorities in these schemes, in a way which is complex and burdensome. In addition, local authorities are responsible for the oversight of

revenue and costs associated with new proposals, including feasibility studies and consultations, while having no direct financial benefit from any gains in oral health.

- 5.134 In light of these challenges, we are proposing to give Secretary of State for Health and Social Care the power to directly introduce, vary or terminate water fluoridation schemes. The Secretary of State for Health and Social Care already has the existing power to decide on whether proposals for water fluoridation should be approved and responsibility for the administration of schemes.
- 5.135 This removes the burden from local authorities and will allow the Department of Health and Social Care to streamline processes and take responsibility for proposing any new fluoridation schemes, which will continue to be subject to public consultation. Central government will also become responsible for the associated work, such as the cost of consultations, feasibility studies, and the capital and revenue costs associated with any new and existing schemes.
- 5.136 As is the case now, once a scheme is agreed, the agreements held with the water companies will continue to be held centrally.

### **Proposals relating to safety and quality**

- 5.137 The government recognises that any health and care reforms must have safety and quality at their core. Legislative changes to wider structures should enhance and support improvements in these areas. The government is therefore proposing to take the opportunity of legislation to bring forward a range of proposals to support and enhance safety and quality in the provision of healthcare services.
- 5.138 The quality and safety measures in the Bill are about transparency and accountability to the public and patient. They build on work of recent years that now needs urgent legislative underpinning to ensure this openness and accountability is embedded into the structure and culture of the NHS via the establishment of an independent Health Services Safety Investigations Body. This will be complemented by proposals on professional regulation, which seek powers to make it easier to ensure that professions protected in law are the right ones and that the level of regulatory oversight is proportionate to the risks to the public, now and in the future. We are introducing a medical examiner system for the purpose of scrutinising all deaths which do not involve a coroner. This will improve the accuracy of cause of death and mortality statistics; increase transparency for the bereaved; and help deter criminal activity and poor practice. We are also proposing to allow the MHRA to develop and maintain publicly funded and operated medicine registries and to work with the NHS to populate and maintain them where there is a clear patient safety or other important clinical interest.

5.139 Taken together, this much needed package of improvements will bolster safety and quality in the NHS, ensuring that patients can have confidence that the care they receive is of the highest quality; that the professions they receive it from are regulated well; that all deaths are scrutinised in as transparent a manner as possible; and that we have the best data available about the medicines they are prescribed.

### **Health Service Safety Investigations Body**

5.140 The Health Service Safety Investigations (HSSI) Bill was introduced in October 2019. We are intending to bring the provisions from the HSSI Bill into the Health and Care Bill.

5.141 Our provisions propose the establishment of a new independent body, the Health Services Safety Investigations Body (HSSIB) to investigate incidents which have or may have implications for the safety of patients in the NHS. This body will be established as an Executive Non-Departmental Public Body with powers to investigate the most serious patient safety risks to support system learning. Independence as a concept is fundamentally important to HSSIB as it will be a crucial way of ensuring that patients, families and staff have trust in its processes and judgements. Investigation reports will make recommendations and require organisations to publicly respond to these measures, within a specified timescale.

5.142 This proposal will:

- prohibit disclosure of information held by the HSSIB in connection with its investigatory function save in limited circumstances set out in the Bill. The aim is to create a 'safe space' whereby participants can provide information to the HSSIB for the purposes of an investigation in confidence and therefore feel able to speak openly and candidly with the HSSIB.
- encourage the spread of a culture of learning within the NHS through promoting better standards for local investigations and improving their quality and effectiveness. To this end the HSSIB will provide advice, guidance and training to organisations.

5.143 The Health Service Safety Investigations Body (the HSSIB) will continue the work of the Healthcare Safety Investigations Branch (HSIB) which became operational in April 2017 as part of NHS Improvement, to conduct high-level investigations into patient safety incidents in the NHS.

5.144 We are responding to concerns raised during the HSSI Bill's first Parliamentary Passage and plan to amend the Bill provision to extend HSSIB's remit to cover healthcare provided in and by the independent sector.

- 5.145 In addition, we are also introducing a power to enable the Secretary of State for Health and Social Care to require the HSSIB to investigate particular qualifying incidents or groups of qualifying incidents.
- 5.146 We will also be including a regulation-making power allowing Secretary of State to set out additional circumstances when the prohibition on disclosure (safe space) does not apply.
- 5.147 The devolved administrations have previously been involved in policy discussions prior to introduction in October 2019, and we will continue to engage with them on any proposed amendments as this work progresses further.

### **Professional regulation**

- 5.148 Professional regulation assures the public that those providing healthcare are qualified, capable and competent to provide safe and effective care. When healthcare professionals do not meet these standards, professional regulators must act to protect the public.
- 5.149 The UK model of professional regulation for healthcare professionals has become increasingly rigid, complex and needs to change to better protect patients, support the provision of health services, and help the workforce better meet current and future challenges.
- 5.150 The proposed powers will make it easier to ensure that professions protected in law are the right ones and that the level of regulatory oversight is proportionate to the risks to the public, now and in the future. This is not about deregulation – we expect the vast majority of professionals such as doctors, nurses, dentists and paramedics will always be subject to statutory regulation. But this recognises that over time and with changing technology the risk profile of a given profession may change and while regulation may be necessary now to protect the public, this may not be the case in the future.
- 5.151 These proposals form part of a wider programme to create a more flexible and proportionate professional regulatory framework that is better able to protect patients and the public. This will enable regulators to ensure that the processes that professionals have to go through to join and stay on a register are proportionate to assure public safety and are not overly bureaucratic.
- 5.152 This reform programme is being taken forward on a four-country basis and we are continuing to engage with the devolved administrations as we take this work forward. We are aiming to consult on our broader reform proposals, which will be delivered through secondary legislation, shortly.

5.153 At present, section 60 of the Health Act 1999 provides powers to make a large number of changes to the professional regulatory landscape through secondary legislation. The proposals in the Health Bill for additional powers will widen the scope of section 60 and enable the Secretary of State for Health and Social Care to make further reforms to ensure the professional regulation system delivers public protection in a modern and effective way and, that professions are regulated in the most appropriate and cost effective manner.

5.154 The proposal includes:

(a) the power to remove a profession from regulation.

- Statutory regulation should only be used where it is necessary for public protection. The level of regulatory oversight for each profession should be proportionate to the activity carried out and the risks to patients, service users and the public.
- The landscape of the health and social care workforce is not static, and risks will change over time as practices, technology and roles develop. While statutory regulation may be necessary now for a certain profession, over time the risk profile may change, such that statutory regulation is no longer necessary.
- A provision to enable the removal of a profession from statutory regulation through secondary legislation will make it easier to ensure that the protections and regulatory barriers that are in place remain proportionate for all health and care professions.

(b) the power to abolish an individual health and care professional regulator.

- There is inevitable duplication in having nine regulatory bodies (10 including Social Work England) performing similar functions in relation to different professions. A reduction in the number of regulators would deliver public protection in a more consistent way, while also delivering financial and efficiency savings. Powers under section 60 already allow for the creation of new regulators through secondary legislation. However, it is not possible to use these powers to close a regulator.

5.155 This change would allow the Secretary of State to exercise this power and enable Parliament to abolish a regulator using secondary legislation, where its regulatory functions have been merged into or subsumed by another body or bodies, or where the professions that it regulates are removed from regulation.

5.156 Reducing the number of regulators is consistent with proposals set out in the July 2019 [Government response](#) to the [Promoting professionalism, reforming regulation](#) consultation. The Secretary of State for Health and Social Care committed to reviewing the number of health and care professional regulators in the November 2020 [Busting Bureaucracy](#) policy paper.

(c) The power to remove restrictions regarding the power to delegate functions through legislation

- Regulators are currently restricted from delegating to another body some of their core functions. This includes the keeping of a register of persons permitted to practise; determining standards of education and training for admission to practise; giving advice about standards of conduct and performance; and administering procedures relating to misconduct and unfitness to practise.
- The removal of these restrictions would enable a single regulator to take on the role of providing a function across some or all regulators. This would enable one regulator to run the registration function on behalf of others to provide a single process for all registrants to follow, which could reduce duplication and costs for registrants. This will help to deliver public protection in a more consistent fashion and may also increase efficiency. Where a function is delegated, the delegating regulator would retain responsibility for that function.

(d) Clarifying the scope of section 60 to include senior NHS managers and leaders and other groups of workers

- Clarifying the definition of professions covered by Section 60 to include senior managers and leaders and other groups of workers would enable us to extend regulation to those groups in the future. We will continue to ensure that regulation is only used where public protection cannot be assured in other ways, such as through employer oversight.
- The [2019 Kark Review](#) of the fit and proper persons test recommended putting in place stronger measures to ensure that NHS senior managers and leaders have the right skills, behaviours and competencies and that those who are unsuitable to work in such roles are unable to do so. However, the Kark Review stopped short of recommending full statutory regulation and NHS Improvement is currently considering how best to achieve this through non-statutory means.
- While there are no plans at this stage to statutorily regulate senior NHS managers and leaders, clarifying the scope of professions who can be

regulated using the powers in Section 60 of the Health Act 1999 to include these groups would enable this to be brought forward in the future, if further measures are needed following those currently being proposed by NHS England/Improvement to address the concerns raised in the Kark Review.

### **Medical examiners**

- 5.157 Previously included in the above mentioned HSSI Bill, with this proposal we plan to amend existing legislation to establish a statutory medical examiner system within the NHS for the purpose of scrutinising all deaths which do not involve a coroner. We support the recommendations of a number of inquiries, including the Shipman Inquiry, to create a new rigorous and unified system of death certification in England.
- 5.158 This proposal will amend the Coroners and Justice Act 2009 to allow for NHS bodies, rather than local authorities, to appoint Medical Examiners. Once in place, we want to ensure that every death in England and Wales is scrutinised, either by a coroner or a medical examiner. The medical examiner system will improve the accuracy of the cause of death and subsequently mortality statistics and will increase transparency for the bereaved and help deter criminal activity and poor practice.

### **Medicines and Healthcare products Regulatory Agency (MHRA) new national medicines registries**

- 5.159 Medicines registries can consolidate prescribing data for specific medicines with data from clinical care and other social administrative databases and can be further developed to capture more detailed and bespoke data on the cohorts of patients receiving these medicines. The data captured in a specific medicine registry can help support the safe use of the medicine.
- 5.160 The aim is to enable the establishment and operation of a comprehensive medicine information system, including data collection from private providers, which will support UK wide medicine registries. Medicine registries have the potential to be an important tool to support improving post-market surveillance of the use of medicines and help ensure consistent implementation of the highest standards of care.
- 5.161 This proposal will allow the MHRA to develop and maintain publicly funded and operated medicine registries so that we can provide patients and their prescribers, as well as regulators and the NHS, with the evidence they need to make evidence-based decisions.



- 5.162 The MHRA can already request for marketing authorization holders (for example, a pharmaceutical firm which sells a medicine in the UK) to capture data to address specific gaps in knowledge regarding the use, safety and effectiveness of medicines.
- 5.163 However, the registries created and controlled by marketing authorization holders have not always delivered the required evidence in reasonable time frames. There is an opportunity to capitalise on the increasing volume of data routinely captured and linked across the healthcare system to build high quality sustainable registries that can deliver for all patients. These legislative changes will allow the MHRA to set up registries themselves, and work with NHS to populate and maintain them where there is a clear patient safety or other important clinical interest. Registries would be established for a medicine where the public need is clear and the benefits of a publicly held national registry that can access routinely collected data where it is available are required. For example, where we know risks of a medicine can result in serious adverse health outcomes and consistent adherence to risk minimisation measures is critical, or where there are substantive unknowns about the safety or effectiveness of a medicine in a population and urgent evidence is required to support safe access to it.
- 5.164 Where a safety issue has led to the introduction of measures to minimise risk to patients, statutory registries with mandated inclusion of data will facilitate the early identification and investigation of potential non-compliance so that additional action can be taken by regulators in conjunction with health service providers at a national, local, or individual patient level. Registries will help understand the impact of changes in risk minimisation measures on the health of patients and help us to understand how to ensure regulatory actions taken to support patient safety and clinical effectiveness are as effective as possible. Registries will also provide an opportunity for patients to actively contribute information on their experiences with specific medicines bringing focus to the safety and clinical effectiveness issues that impact most on their lives.

### **Hospital food standards**

- 5.165 The Independent Review of NHS Hospital Food published on the 26th October 2020 recommended for improved NHS food and drink standards for patients, staff and visitors to be put on a statutory footing. We support this recommendation and believe that putting hospital food standards on a statutory footing will deliver for the first time, mandatory minimum standards for the provision of good hydration and nutrition in the NHS.
- 5.166 Adopting statutory standards will also provide NHS hospital staff with improved access to healthier options and instil greater confidence in the public that the NHS

is committed to deliver appropriate levels of nutrition and hydration, as well as good quality food.

- 5.167 We propose to grant the Secretary of State for Health and Social Care powers to adopt secondary legislation that will implement the national standards for food across the NHS.

### **Reciprocal healthcare agreements with Rest of World countries**

- 5.168 The UK has multiple reciprocal healthcare agreements with countries outside the EEA and Switzerland ('Rest of World countries'), such as Australia and New Zealand. However, without financial reimbursement or data sharing mechanisms, these agreements are limited in scope and reach.
- 5.169 In line with the Government's Global Britain strategy, looking to invest and strengthen the UK's relationships with countries across the globe and strengthen international healthcare cooperation, the proposed legislation will enable the government to implement more comprehensive reciprocal healthcare agreements with Rest of World countries subject to negotiations. Under the current legislation, the UK is limited to implementing such arrangements with the EU, EEA, EFTA blocs or their Member States. This would offer the opportunity to strengthen existing agreements with Rest of World countries and agree new reciprocal healthcare arrangements with Rest of World countries of strategic importance.
- 5.170 Comprehensive reciprocal healthcare agreements with Rest of World countries could make healthcare more accessible for UK residents when they travel abroad for tourism or short-term business purposes and support individuals with long-term conditions who usually pay higher travel insurance premia or face difficulties in getting comprehensive insurance cover. They can also foster closer collaboration on healthcare with our international partners, supporting improved health outcomes for all.
- 5.171 In addition to supporting people access necessary healthcare, the proposed legislation will enable other advantages for agreements with Rest of World countries:
- The introduction of a reimbursement mechanism means that healthcare costs could be covered, so that no healthcare system will be left worse-off.
  - The exchange of data between countries for the purposes of reimbursement will allow for constant monitoring and evaluation of the cost-effectiveness of these agreements over time.

- The responsibility for paying healthcare charges will lie with governments, thus guaranteeing income for the NHS while eliminating most of the financial burden for the traveller.

5.172 The scope for any new agreements will be agreed across relevant government departments and will be tailored to meet our national interest with input from the devolved administrations as well as relevant operational partners.

## 6. Annex B: Integration, partnerships and accountability

### Working together

- 6.1 Healthy, fulfilled, independent and longer lives for the people of England will require health and care services, local government, NHS bodies, and others to work ever more closely together. Different professions, organisations, services and sectors will work with common purpose and in partnership. This will be especially important when we seek to focus on the people and communities that are most in need of support.
- 6.2 In many ways, the professionals are ahead of the organisations. Multi-disciplinary working has been a recognised part of good care for many years now. But the organisations are catching up. We have seen real advances in recent years in forms of joint working, with a great deal of commitment in parts of local government and the NHS to developing broadly-based 'integrated care systems', many of which are now starting to make a real difference.
- 6.3 One of the most impressive and heartening features of the work to develop integrated care systems has been the emphasis on shared purpose over structures and titles. We are very mindful that any statutory framework for integrated care should preserve, spread and enhance this feature. The point was summed up with great clarity in the recent consultation on integrated care issued by NHS England which set out the following four purposes for systems:
- (a) Improving population health and healthcare;
  - (b) Tackling unequal outcomes and access;
  - (c) Enhancing productivity and value for money; and
  - (d) Helping the NHS to support broader social and economic development.
- 6.4 These purposes provide both a formidable challenge and an excellent basis for collaborative working. Much of this work is happening at the level of 'place'.

### The primacy of place

- 6.5 Many people who are making integration happen emphasise the importance of 'place' (which is most usually aligned with either CCG or local authority

boundaries) in the joining up of services to support people to live well. The most successful integrated care systems have often concentrated on developing the places within their wider geography to thrive and to find shared priorities to work on. Many provider organisations and groupings of organisations such as primary care networks look to their 'place' as their primary focus.

- 6.6 Places vary by population and geography, and they also vary in the history and strength of the connections between the key agencies that make joined up services and improvement to outcomes happen. It is vital that we recognise this as it gives us both assets and challenges: we must not damage the former in tackling the latter (as can happen when reform is attempted). This has led us – building on the experience of those making integrated care happen - to think hard about the right balance between what needs to be prescribed by legislation and other means and what should rightly be left to local and system level decisions.

## **Two forms of integration**

- 6.7 The increased importance of integration within health and social care, is, of course, driven by the vital importance of arranging care around people and the complete picture of their health and care needs, as well as the wider demographic imperatives of getting ahead of the curve on prevention and of supporting people with multiple health and care needs (especially in later life and especially in disadvantaged communities). It is also, as the third of the purposes set out by NHS England notes, about ensuring that we get the best possible value for money for the people we serve – the patients, service users and taxpayers of England.
- 6.8 As is described elsewhere in this paper, we intend to introduce legislation that removes the needless bureaucracy that has grown up around the commissioning framework for the NHS. This will allow the NHS to shift away from an adversarial and transactional system centred on contracting and activity payments to one that is far more collaborative and dedicated to tackling shared problems. While NHS provider organisations will retain their current structures and governance, they will be expected to work in close partnership with other providers and with commissioners or budget holders to improve outcomes and value. This is what the best organisations already do, and the work of early wave integrated care systems in recent years has shown how a collaborative approach can work well - even in a framework that was not specifically designed to support it.
- 6.9 There are, then, two forms of integration which will be underpinned by the legislation: the integration within the NHS to remove some of the cumbersome boundaries to collaboration and to make working together an organising principle; and the integration between the NHS and others, (principally local authorities), to deliver improved outcomes to health and wellbeing for local people.

- 6.10 This adds complexity and will require thoughtful handling within systems with respect to governance and accountability; but we need both forms of integration if we are to achieve the improvements in outcomes that we seek. A more internally collaborative NHS will be a better, more coherent partner for local government and others. A wider partnership that includes local government and which enables a shift towards population health will deliver health, care and economic benefits and contribute to the levelling up agenda as well.
- 6.11 There is an important difference between the NHS and local government: each has a distinct line of accountability. Local government is, of course, held to account by local people and their elected representatives. NHS services and organisations are scrutinised by local authority overview and scrutiny committees and work with them closely on a number of issues – but their primary form of democratic accountability is (via NHS England) to national government and ultimately to Parliament. This will be important to recognise and reflect in the legislation but, as the pioneer ICSs have shown, it is no barrier to shared purpose, shared leadership and the pursuit of outcomes and service integration to improve the lives of local people.

## **The role of legislation**

- 6.12 The purpose of legislation in this context is to create an enabling framework for local partners to either build upon existing partnerships at place and system levels or, where these partnerships are yet to form in earnest, to begin the work of aligning services and decision making in the interests of local people.
- 6.13 The three factors that frame our proposed approach are:
- (a) The importance of shared purpose within places and systems;
  - (b) The recognition of variation – some of it warranted – of form and in the potential balance of responsibilities between places and the systems they are part of;
  - (c) The reality of differential accountabilities, including the responsibility of local authorities to their elected members and the need for NHS bodies to be able to account for NHS spend and healthcare delivery and outcomes.
- 6.14 Legislation in this context needs to be used in a targeted way and in conjunction with a great deal of local and system level freedom to make arrangements that work for all partners. We will not, for example, be making any legislative provision about arrangements at place level- though we will be expecting NHSE to work with ICS NHS bodies on different models for place-based arrangements.

- 6.15 NHS England's November consultation on integrated care generated a large number of responses from individuals and key organisations. It concluded that the government should bring forward legislation to underpin ICSs; that the legislation should allow a significant degree of local flexibility; and should not undermine effective place-based arrangements. It also recommended that ICSs should be underpinned by both an NHS ICS statutory body, with stronger responsibilities for commissioning primary medical, dental, ophthalmology and pharmaceutical services, and a wider statutory health and care partnership.
- 6.16 Having considered the response to the NHS England consultation, the government has concluded that the allocative functions of CCGs should be held by a system level body responsible for integrated care - what we are calling an ICS NHS Body.
- 6.17 Many of the responses served to reinforce the importance of the key factors for framing legislation set out above. As the response from The King's Fund noted 'We also recognise that there is a careful balance to be struck between using legislation to clarify and improve accountability and transparency, while also creating the flexibilities to allow systems to develop the arrangements best suited to their local contexts and population needs. Difficult trade-offs will be involved in resolving some of the issues we have highlighted in this section and we do not underestimate the complex nature of the decisions involved in doing so'.
- 6.18 These considerations have led us to the following model:
- (a) Place based arrangements between local authorities, the NHS and between providers of health and care services are at the core of integration and should be left to local organisations to arrange. We expect local areas to develop models to best meet their local circumstances. We would expect NHS England and other bodies to provide support and guidance, building on the insights already gained from the early wave ICSs. The statutory integrated care system (ICS) will also work to support places within its boundaries to integrate services and improve outcomes – recognising that different places will be at different stages of development and face different issues.
  - (b) Health and Wellbeing Boards will remain in place and will continue to have an important responsibility at place level to bring local partners together, as well as developing the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy, which both HWBs and ICSs will have to have regard to. We will support HWBs and ICSs, including with guidance, to work together closely to complement each other's roles, and to share learning and expertise.
  - (c) A statutory ICS will be formed in each ICS area. These will be made up of a statutory ICS NHS body and a separate statutory ICS Health and Care Partnership, bringing together the NHS, local G

- (d) government and partners e.g. community health providers. We would expect the public name of each ICS NHS Body to reflect its geographical location – for example, NHS Nottinghamshire or NHS North West London.
- (e) The ICS NHS Body will take on the commissioning functions of the CCGs and some of those of NHS England within its boundaries, as well as CCG's responsibilities in relation to Oversight and Scrutiny Committees. It will not have the power to direct providers, and providers' relationships with CQC will remain unchanged.
- (f) Each ICS NHS body will have a unitary board, and this will be directly accountable for NHS spend and performance within the system, with its Chief Executive becoming the Accounting Officer for the NHS money allocated to the NHS ICS Body. The board will, as a minimum, include a chair, the CEO, and representatives from NHS trusts, general practice, and local authorities, and others determined locally for example community health services (CHS) trusts and Mental Health Trusts, and non-executives. ICSs will also need to ensure they have appropriate clinical advice when making decisions. NHSE will publish further guidance on how Boards should be constituted, including how chairs and representatives should be appointed.
- (g) The ICS NHS body will be responsible for the day to day running of the ICS, and NHS planning and allocation decisions. It will be responsible for:
  - developing a plan to address the health needs of the system;
  - setting out the strategic direction for the system; and
  - explaining the plans for both capital and revenue spending for the NHS bodies in the system.

6.19 Discussions with a number of stakeholders including the Local Government Association has led us to the conclusion that there is a strong case for the governance arrangements for an ICS to include an ICS Health and Care Partnership made up of a wider group of organisations than the ICS NHS 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 ICS NHS Body and local authority would have to have regard to this plan. The Health and Care 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.

6.20 Members of the ICS Health and Care Partnership could be drawn from a number of sources including Health and Wellbeing Boards within the system, partner



organisations with an interest in health and care (including Healthwatch, voluntary and independent sector partners and social care providers), and organisations with a wider interest in local priorities (such as housing providers). Our intention is to specify that an ICS should set up a Partnership and invite participants, but we do not intend to specify membership or detail functions for the ICS Health and Care Partnership - local areas can appoint members and delegate functions to it as they think appropriate.

- 6.21 The ICS Health and Care Partnership could also be used by NHS and Local Authority Partners as a forum for agreeing co-ordinated action and alignment of funding on key issues, and this may be particularly useful in the early stages of ICS formation. We will, working with NHSE and the LGA, also issue guidance to support ICSs in establishing these bodies. This, along with the flexibilities at place level, will allow systems to decide how much or how little to do at these different levels and will also potentially allow them to vary these arrangements over time as the system matures and adapts. We know that this element of flexibility has been of value to the early wave ICSs where there are many (and different) examples of partnership boards and of arrangements at place level. In many cases, partnership boards have served as a way to identify, develop and drive shared priorities and projects between local government and NHS partners.
- 6.22 Taken together, we think these arrangements provide the right balance between recognising the distinctive accountabilities and responsibilities of the NHS, local authorities and other partners while also strongly encouraging areas to go further in developing joint working and decision-making arrangements that deepen and improve over time in the interests of local people.

## 7. Annex C: Stakeholder Engagement

7.1 Despite the unprecedented context under which we have developed this paper, we have still managed to engage with a range of stakeholders from across the health and care system, both through roundtables and smaller discussions.

7.2 We would like to extend our sincere thanks to the following organisations for discussing the themes and proposals at the centre of this paper with us.

- Academy of Medical Royal Colleges
- Age UK & Care Support Alliance
- Alzheimer's Society
- Association of Directors of Adult Social Services (ADASS)
- Association of Directors of Public Health
- Association of Pharmacy Technicians
- British Medical Association
- Care England
- Care Providers Alliance
- Care Quality Commission
- Care UK
- Carers UK
- Centre for Ageing Better
- Centre for Mental Health
- Faculty of Public Health
- Health Education England
- Health Foundation
- Healthcare Safety Investigation Branch

- Healthwatch England
- Independent Healthcare Provider Network
- Institute for Government
- International Longevity Centre UK
- Learning Disability England
- Local Government and Social Care Ombudsman
- Local Government Association
- National Association of Primary Care
- National Care Forum
- National Data Guardian
- National Voices
- NHS Assembly
- NHS Blood and Transplant
- NHS Business Services Authority
- NHS Clinical Commissioners
- NHS Confederation
- NHS Digital
- NHS Employers
- NHS England
- NHS Improvement
- NHS Providers
- NHS Resolution
- National Institute for Health and Care Excellence

- Nuffield Trust
- Policy Exchange
- Public Health England
- Royal College of General Practitioners
- Royal College of Nursing
- Royal Pharmaceutical Society
- Social Care Institute for Excellence
- Skills for Care
- SOLACE
- The King's Fund
- The Patients Association
- Think Local Act Personal
- UK Home Care Association
- UNISON



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