

Board of Directors' Meeting 10 September 2021

Agenda item	197 /21
Report	Governance Report – September 2021
Executive Lead	Presenter: Angela Wendzicha, Director of Corporate Affairs
Author	Julie Dawes, Interim Director of Corporate Affairs
Link with the BAF	B8: this report provides a horizon scan of regulatory, statutory or legislative reviews, updates and changes
How does this paper support Trust Values	This report supports the core value of Ambitious ensuring the Board of Directors is aware of any changes in the regulatory or legislative landscape as soon as possible
Purpose	For decision <input type="checkbox"/> For assurance <input type="checkbox"/> For information <input checked="" type="checkbox"/>
Executive Summary (including reason for the report, background, key issues and risks)	<p>The report includes sections on:</p> <ul style="list-style-type: none"> • Health and Care Bill • ICS and place based partnerships • Integrated care board governance • Working together at scale: Guidance on provider collaboratives • Single Oversight Framework • New Digital Framework • Consultation on new race equality strategy • The continuing cost of COVID-19 • Statutory COVID-19 public inquiry
Due Diligence (include the process the paper has gone through prior to presentation at Board of Directors' meeting)	This report has not been received elsewhere prior to its presentation to the Board of Directors
Board powers to make this decision	No decisions are required by this paper.
Who, What and When	Actions required will be led by the relevant Executive Director
Recommendations	It is recommended that the Board of Directors receive this report for information.
Appendices	<p>Appendix 1: Health and Care Bill Briefing</p> <p>Appendix 2: Integrated Care Board Governance Briefing</p> <p>Appendix 3: Single Oversight Framework Metrics</p>

Governance Report – September 2021

1 Introduction

This report brings together a number of items that evidence or strengthens the corporate governance arrangements and systems of internal control within the Trust.

It is also intended to provide a brief summary of any regulatory, statutory or legislative changes, health management and policy alerts or corporate governance developments since the last Board meeting in July 2021.

2 Health and Care Bill

On 6 July, the Government published a Health and Care Bill. This follows a set of proposals for legislative change originally brought forward by NHS England and NHS Improvement (NHSE/I) in Autumn 2019 and prior to the COVID-19 pandemic. These proposals were further developed in the Integrating Care consultation with regard to system working and, most recently, in the Department of Health and Social Care's (DHSC's) Integration and Innovation white paper published in February this year. It also incorporates proposals for the Health Service Safety Investigations Body which were part of previous legislation which did not make it on to the statute book during a previous session of parliament.

The majority of the Bill is focused on developing system working, with ICS being put on a statutory footing. It also formally merges NHS England and NHS Improvement, and gives the Secretary of State a range of powers of direction over the national NHS bodies and local systems and trusts. Other measures proposed include putting the Healthcare Safety Investigation Branch (HSIB) on a statutory footing; a new legal power to make payments directly to social care providers; the development of a new procurement regime for the NHS; and a new duty on the Secretary of State to report on workforce responsibilities.

The Government has stated that the Health and Care Bill will allow it to build and shape a health system that is better able to serve the people of England in a fast-changing world. Its intention is to create a system that is more accountable and responsive to the people that work in it and the people that use it. At 135 clauses and 16 schedules, it is a long piece of legislation which is divided into 6 parts:

- Part 1 – Health service in England: integration, collaboration and other changes
- Part 2 – Health and adult social care: information
- Part 3 – Secretary of state's powers to transfer or delegate functions
- Part 4 – The Health Services Safety Investigations Body
- Parts 5 and 6 – Miscellaneous and general

The NHS Providers briefing sets out an overview of the proposals, provides an excellent summary of the key parts of the Bill as well as NHS Providers' view on these provision. A copy of the briefing is attached to this report as Appendix 1 and can also be found [here](#).

In addition, the NHS Confederation issued a Parliamentary Briefing on the Bill summarising healthcare leaders' views and highlighting five key areas of concern. The briefing be found [here](#).

3 ICS and place based partnerships

On 2 September, NHSE/I published several further guidance documents, including [Thriving places: guidance on the development of place-based partnerships as part of statutory ICSs](#) and [ICS implementation guidance on partnerships with the voluntary, community and social enterprise \(VCSE\) sector, effective clinical and care professional leadership, and working with people and communities](#).

NHS Providers have produced a useful briefing which summarises these resources and sets out their initial analysis of the implications for trusts. The briefing document can be found [here](#).

4 Integrated care board governance

NHSE/I published several integrated care system (ICS) guidance documents and accompanying resources on 19 August to support systems' transition into statutory integrated care boards (ICBs) by 1 April 2022. The NHS Providers briefing document summarises these resources and provides detailed commentary on the ICB functions and governance guidance, model constitution and ICS people guidance. A copy is attached to this report as Appendix 2 and can also be found [here](#).

It should also be noted that there are new names for the different parts of the ICS. The ICS will be made up of:

NHS Integrated Care Board (ICB)

- Chair (appointed by NHSE, approved by Secretary of State)
- Chief Executive (appointed and approved by NHSE – will involve the Chair if already in post. Recruitment nationally for the Chief Executive post commenced in early September).
- The Board: Independent Chair, minimum 3 ordinary members, minimum of 2 independent Non-executive Directors
- Duties: finance, health and wellbeing, quality of services, efficiency, and sustainability
- Functions discharged at Place - Place Based Partnerships (PBP)

Integrated Care Partnership

(i.e. the current Integrated Care Partnership (ICP) for Rotherham. An update on the current position is provided under agenda item 181/21.

- Responsible for Integrated Care Strategy.

The Interim guidance on the functions and governance of the ICB sets out the indicative mandatory governance requirements for ICBs, building on what is currently described in draft legislation and NHSE/I policy (including the ICS Design Framework). This guidance document aims to support systems to make the necessary preparations before ICSs are placed on a statutory footing, which is expected in April 2022. It also provides some key considerations to inform local decisions on the design and implementation of ICBs and ICPs.

The Model Constitution and supporting notes were also included and aims to support the development of ICB constitutions, which will need to include information on the composition of the board of the ICB and the appointments process for the board.

The governance for ICBs has helped to develop the draft governance for our Place. As this is still emergent and subject to the publication of the legislation in September, it is currently expected that this will form part of our Strategic Board Forum discussion in October and/or December 2021.

5 Working together at scale: Guidance on provider collaboratives

Following the recent publication of the ICS Design Framework (16 June), on 10 August, NHSE/I published further guidance on provider collaboratives. This document "[Working together at scale: guidance on provider collaboratives](#)" sets out NHSE/I's expectations for how providers should work together in Provider Collaboratives, as well as the benefits, enablers, and possible governance arrangements. It positions Provider Collaboratives as one of several key components of system working and ICS delivery.

NHS Providers have produced a detailed briefing which can be found [here](#).

6 Single Oversight Framework

As reported in the previous Governance Report presented at the July board meeting, at the end of June, NHS England published the System Oversight Framework (SOF) for 2021/22. This document describes NHSE/I's approach to oversight for the year, one that reinforces system-led delivery of integrated care and sets out the monitoring and support arrangements at Integrated Care System, Clinical Commissioning Group and Trust level. A copy of the full table of indicators used in the SOF is attached for future reference at Appendix 3.

7 New Digital Framework

On 31 August, NHSX published the '[What Good Looks Like \(WGLL\) Framework](#)'. WGLL is directed at all NHS leaders, as they work with their system partners, and sets out what good looks like at both a system and organisation level. It describes how arrangements across a whole ICS, including all its constituent organisations can support success.

WGLL is included in both the ICS Design Framework and the NHS Operational Planning and Contracting Guidance, reflecting the expectation that the standards in the WGLL framework will be used to accelerate digital and data transformation.

The WGLL framework has 7 success measures:

1. Well led
2. Ensure smart foundations
3. Safe practice
4. Support people
5. Empower citizens
6. Improve care
7. Healthy populations

The WGLL programme draws on local learning. It builds on established good practice to provide clear guidance for health and care leaders to digitise, connect and transform services safely and securely. This is intended to improve the outcomes, experience and safety of our citizens.

Full details of the publication can be found [here](#).

8 Consultation on new race equality strategy

NHSE/I is developing a long-term race equality strategy for the NHS, and on 5 August launched a consultation to gather views. The aim of the strategy is to establish standards for advancing race equality, eliminating discrimination and fostering good relations in the NHS.

The race equality strategy is aligned with the work undertaken on Model Employer, the NHS Long Term Plan and the People Plan 2020/21. The new strategy is expected to be published in October 2021.

All NHS staff, including bank and agency staff, professional bodies and staff-side representatives are invited to contribute and share their thoughts via an online form by 12 September 2021. In addition, NHSE/I are planning a series of virtual listening events where Chatham House rules apply.

9 The continuing cost of COVID-19

The COVID-19 pandemic has increased the cost of running frontline NHS services by £4-5bn a year. These costs are in addition to other key financial factors, such as the need to fund capital investment and recover care backlogs, and they will be with us for the duration of the three-year period that is expected to be covered by the upcoming Comprehensive Spending Review (CSR).

On 2 September, NHS Providers and the NHS Confederation published a joint briefing based on survey data from 54% of the provider sector, which explains the long-term impact of the pandemic on the NHS's day-to-day running costs, and calls on the government to ensure these costs are met in full.

The full report can be found [here](#).

10 Statutory COVID-19 public inquiry

In June 2021, NHSE/I notified local NHS organisations that they must start preparing for the statutory public inquiry into the COVID-19 pandemic. It is understood that any organisation might be called upon to provide evidence for the statutory inquiry, and individuals may be required to give evidence under oath. Government announced in May that a statutory public inquiry would begin in spring next year.

Local NHS leaders have been asked to consider “four key areas of action”:

- “ensuring robust and comprehensive records management;
- embedding systematic approaches to log key leavers, carry out exit processes and retain contact details;
- considering wellbeing support for staff who may have to provide evidence; and
- appointing a named inquiry lead.”

NHSE/I also issued a “stop notice” instructing staff to “retain all documents” and suggests local NHS organisations may want to “adapt” the stop notice for their own use. NHSE/I will set up a programme management office for the public inquiry. Its work will include coordinating “support on good practice (e.g. training)” in relation to the inquiry. The message was delivered by Amanda Pritchard in her former role as NHS England’s deputy chief executive, as part of her regular Healthcare leaders newsletter.

The Trust has commenced the required preparatory work to ensure that appropriate arrangements are put in place and it is intended that an update report will be presented at the November meeting as a means of providing board members with the necessary assurance about the Trust's preparedness for the proposed public inquiry in Spring 2022.

11 Recommendation

It is recommended that the Board of Directors receives this report for information.

The Health and Care Bill

The government has today published the Health and Care Bill. This briefing sets out an overview of proposals, a summary of the key parts of the Bill as well as NHS Providers' view on these provisions. We have focused on the areas of particular interest to members and where we will seek to influence the Bill as it progresses through parliament. If you have any comments on the proposals that you would like to help inform our work on the Bill, please contact [Cath Witcombe](#), public affairs manager, and [Finola Kelly](#), senior legislation manager.

Overview

- The publication of the Health and Care Bill follows a limited set of proposals for legislative change originally brought forward by NHS England and NHS Improvement (NHSE/I) in autumn 2019 before the COVID-19 pandemic. These were further developed in the *Integrating Care* consultation with regard to system working and, most recently, in the Department of Health and Social Care's (DHSC's) *Integration and Innovation* white paper published in February this year. It also incorporates proposals for the Health Service Safety Investigations Body which were part of previous legislation which did not make it on to the statute book during a previous session of parliament.
- The majority of the Bill is focused on developing system working, with integrated care systems (ICSs) being put on a statutory footing. It also formally merges NHS England and NHS Improvement, and gives the secretary of state a range of powers of direction over the national NHS bodies and local systems and trusts. Other measures proposed include putting the Healthcare Safety Investigation Branch (HSIB) on a statutory footing; a new legal power to make payments directly to social care providers; the development of a new procurement regime for the NHS; and a new duty on the secretary of state to report on workforce responsibilities.
- The government has stated that the Health and Care Bill will allow it to build and shape a health system that is better able to serve the people of England in a fast-changing world. Its intention is to create a system that is more accountable and responsive to the people that work in it and the people that use it. We support this direction of travel and the opportunity the Bill presents to design the right system architecture that will deliver sustainable high-quality care for the future. We believe there are a number of improvements that can be made which will make this the transformative piece of legislation the government wants it to be.

- The Bill introduces a two-part statutory ICS model, with an ICS in future comprising an integrated care board (ICB), bringing together the organisations that plan and deliver NHS services within the geographic area covered by the ICS (the white paper called this part the ICS NHS Body) and an integrated care partnership (ICP), bringing together a broad alliance of organisations related to improving health and care (the white paper called this part the Health and Care Partnership).
- The Bill includes provisions which cumulatively amount to far-reaching powers for the secretary of state. This includes powers of direction over NHS England and the ability to intervene at any stage in local service reconfigurations. We are concerned to ensure the NHS' clinical and operational independence and avoid the risk of political interference in the provision of services and will therefore seek appropriate safeguards to balance these powers.
- The Bill gives NHS England the power to set capital spending limits for foundation trusts. We will be seeking to amend the current proposals by asking parliament to consider adding a number of safeguards which were previously agreed between NHS Providers and NHSE/I in 2019.
- We welcome a new duty on the secretary of state to set out how workforce planning responsibilities are to be discharged, but believe that an additional duty should be added to the Bill to ensure the development of regular, public, annually updated, long-term workforce projections. There should also be a duty to regularly update parliament on the government's strategy to deliver those long-term projections, including its approach to providing the required funding.
- The Bill also includes a number of changes to local financial arrangements. This includes setting requirements to meet financial objectives and balance, with NHS England having the ability to set additional and mandatory financial objectives specifically for NHS trusts. While we support greater integration within health services and across health and care, in the event that local organisations believe an impossible task has been set it is important that the legislation also establishes clear routes for recourse.
- We strongly support putting the Health Service Safety Investigations Body (HSSIB) on a statutory footing and setting out the framework for its conduct of safe space investigations so that the NHS can improve patient care and learn from when things go wrong. Nevertheless, we are keen to ensure that the Bill provisions genuinely enable the HSSIB's independence, which is crucial to its ability to carry out its intended systemic safety role, as well as protecting the integrity of safe space.
- As the country emerges from the pandemic, the NHS continues to face considerable challenges including in direct response to COVID-19; the backlog of care and restoration of elective care; persistent and severe pressures on the workforce; and the impact of prolonged under-investment. The impact of amending the legislative framework within which the NHS operates and the

additional burden this will create for the NHS and its staff should not be underestimated at this time.

- We will continue to work with the government, parliament and stakeholders as the Bill progresses, highlighting where we believe the legislation could be improved and amended. It will be vital for the government to continue listening to the views of those on the frontline to ensure the proposals best support the NHS and the patients and service users it cares for.

At 135 clauses and 16 schedules the Health and Care Bill is a long piece of legislation. It is divided into 6 parts covering the following areas:

Part 1 – Health service in England: integration, collaboration and other changes

Part 2 – Health and adult social care: information

Part 3 – Secretary of state’s powers to transfer or delegate functions

Part 4 – The Health Services Safety Investigations Body

Parts 5 and 6 – Miscellaneous and general

Part 1 – Health service in England: integration, collaboration and other changes

NHS England (clauses 1-11; schedule 1)

Summary

These clauses made a number of provisions to NHS England and its ways of working. This includes:

- renaming the NHS Commissioning Board to NHS England
- giving the secretary of state the power to veto any proposal from NHS England on the commissioning of specialised services
- making it easier for the secretary of state to change the mandate in-year
- introducing a duty on NHS England to have regard to the likely effects of making any decision to exercise its functions on:
 - the health and well-being of the people of England
 - the quality of services provided, changes to prevention, diagnosis or treatment
 - efficiency and sustainability across the NHS.

Further provisions include:

- Broadening the powers of NHS England to give assistance and support to any provider of NHS services or any body carrying out the functions of the NHS (this includes integrated care boards (ICBs) and non-NHS bodies providing NHS services).

- Enabling NHS England to give directions to one or more ICBs in respect of any of the ICB's functions and payments. Enabling NHS England to give directions to one or more ICBs in respect of any of the ICB's functions and payments. Regulations may be made limiting this power. The ICB becomes liable for any tort arising from the direction.
- Extending the right to be included in public involvement and consultation to carers and representatives.

In addition:

- NHS England will be subject to a duty to prepare consolidated accounts for NHS trusts and foundation trusts and submit them to the secretary of state, the comptroller and auditor general and submit them to parliament along with any report of the comptroller and auditor general upon them.
- The secretary of state will have the power to direct NHS England to use payments made to it for the purpose of integration and to direct how such payments may be used. NHS England will also have the right to make payments to ICBs in respect of integration.
- The power of the secretary of state to make regulations in respect of payments for quality will be removed and such payments will in future be able to be designated by direction.
- The right of NHS England to accept secondments from designated bodies is extended.

Key clauses and NHS Providers' view

Clause 3: NHS England mandate

This clause removes the requirement for a mandate to be set before the start of each financial year. Instead, a mandate can be set at any time and remain in force until it is replaced by a new mandate. The statutory link between the mandate and the annual financial cycle will be removed and the Bill proposes that NHS England's annual limits on capital and revenue resource be given statutory force through the financial directions.

NHS Providers' view

There is a logic to creating the potential for a longer running and more strategic mandate. However, there is also a need to maintain the link between the 'asks' of the NHS and the resourcing envelope available and to avoid a situation where priorities could change within a year (or any timeframe), and potentially be unfunded. These proposals will remove the duty to set NHS England's capital and revenue resource limits in the mandate itself. Instead, these limits will be set within the annual financial directions that are routinely published, and which will in future also be laid in parliament. There is a risk that disconnecting the mandate from financial planning could lead to inadequate funding, leaving the NHS unable to deliver on government priorities.

Clause 4: NHS England: wider effect of decisions

This clause places a duty on NHS England to have regard to the likely effects of making any decision to exercise its functions on the health and wellbeing of the people of England; the quality of services provided; changes to prevention, diagnosis or treatment; and efficiency and sustainability across the NHS. NHS England must produce guidance as to how it will exercise this duty.

NHS Providers' view

This clause requires NHS England to have regard to the 'triple aim' duty, which will also apply to ICBs, trusts, foundation trusts (see clauses 15, 43 and 56). This clause seeks to legislate for decision-making which balances health and wellbeing, the quality of services, and efficiency and sustainability within a constrained resource envelope. While in many ways this reflects the status quo, this clause does offer a new legal basis for decisions and could be used to justify greater expenditure on some services rather than others. Our expectation is that such decisions would always be clinically-led and evidence-based, but this may nevertheless be concerning for patient groups with rare diseases or for services which have been subject to local variation in the past. This clause may also become of greater concern should the clinical and operational independence of the NHS become diminished as a result of the proposed strengthened powers of direction for the secretary of state. We would welcome members' views on the practical impact of this clause, including how it may impact commissioning decisions and services.

Clause 9: Funding for service integration

This makes provision for a fund for the integration of care and support with health services, known as the Better Care Fund (BCF), and allows for the secretary of state to provide directions requiring NHS England to use a specified amount of this annual payment for purposes relating to service integration. Where the secretary of state has given a direction about the use by NHS England of the annual amount, NHS England may direct ICBs that a designated amount of the annual payment is to be used for purposes of service integration.

NHS Providers' view

We understand that this is a technical amendment to decouple the BCF from the NHS England mandate, rather than to fundamentally change the focus of the BCF.

Integrated care boards and Integrated care boards: functions (clauses 12-19; schedules 2 and 3)

Summary

Integrated care systems (ICSs) currently operate as health and care organisations working together as coalitions of the willing to coordinate, integrate and plan services, with a view to improving population health and tackling health inequalities. The Bill introduces a two-part statutory ICS model, with an ICS in future comprising:

- an integrated care board (ICB), bringing together the organisations that plan and deliver NHS services within the geographic area covered by the ICS (the white paper called this part the ICS NHS Body)
- an integrated care partnership (ICP), bringing together a broad alliance of organisations related to improving health and care (the white paper called this part the Health and Care Partnership).

This chapter of clauses and its schedules amend the National Health Service Act 2006 to describe the composition, constitution and functions of ICBs. The ICB will take on the commissioning functions and duties of clinical commissioning groups (CCGs), which will be abolished on the same day that ICBs are established as corporate bodies (clause 13). The CCG(s) within the system footprint must consult with relevant parties and propose the first ICB constitution, taking into account any guidance published by NHS England.

An ICB will have several duties (clauses 15 and 19), including but not limited to: improving the quality of services, reducing inequalities in access and outcomes; promoting integration between health, social care and wider services, and having regard to the 'triple aim' of better health for everyone, better care for all and efficient use of NHS resources. Further, ICBs must ensure patients and communities are involved in the planning and commissioning of services; NHS England must publish guidance for ICBs on the discharge of their functions; and ICBs must have regard to this guidance.

The composition of an ICB will, at a minimum, consist of a chair, chief executive and at least three other members. One of those members is nominated by NHS trusts and foundation trusts, one by general practice and one by local authorities (LAs) providing services within the ICB footprint. Beyond that, local systems will have the flexibility to determine any further membership. NHS England will appoint the ICB chair and have the power to remove them, with secretary of state approval in either instance. The ICB chief executive will be appointed by the chair, with NHS England approval. The chair will approve the appointment of ordinary members (that is, member other than the chair or chief executive). Each ICB must publish its constitution, which should set out how members are to be appointed and by whom, and the process for nominating ordinary members (schedule 2). The

constitution must also provide for committees or sub-committees of the ICB to be formed. NHS England will publish guidance in relation to the selection of candidates.

Clause 19 (along with schedule 2) further sets out that the ICB and its 'partner' trusts and foundation trusts must prepare a five-year plan (with regard to and in consultation with relevant Health and Wellbeing Boards [HWBs] and their strategies) setting out how they propose to exercise their functions. They must also create a joint capital plan for a period specified by secretary of state. The ICB must prepare accounts and create an annual report. NHS England will conduct a performance assessment of each ICB each financial year. If NHS England deems an ICB to be failing or at risk of failure, NHS England will have powers of direction over the ICB (including prohibiting or restricting the ICB from delegating functions) and may terminate the appointment of the chief executive and direct others to exercise the ICB's functions.

The Bill confers a duty on ICBs to commission primary care, and NHS England may direct an ICB to exercise any of NHS England's primary care functions (schedule 3).

NHS Providers' view

The national role in developing system working

We support the government's ambition to embed the success of collaboration and system working, as especially seen during the COVID-19 response. However, some trust leaders are increasingly concerned about a mismatch between the pace and scale of change, and the sector's capacity to carry out this major transformation at the same time as they are grappling with pandemic recovery. We urge flexibility around the timing of implementation, such as allowing for ICBs to take on functions when they judge themselves ready, enabling ICBs to exercise functions jointly with NHS England, and clarifying whether there will be a shadow implementation period.

We are keen to see an enabling, flexible legislative framework that accelerates the current direction of system working. While the narrative in the white paper aligned with this approach, we are concerned that the provisions in the Bill and accompanying guidance from NHSE/I and DHSC to date risk undermining this intention. For example, the level of detail around the ICB's membership, appointments and composition, alongside provision for an increased level of control and direction over ICBs from NHS England and secretary of state, indicates a shift further towards a tightly managed, centrally controlled NHS system architecture. Elsewhere in the Bill, for example, NHS England's and the secretary of state's duties to promote autonomy are removed (clause 62). This is framed in the context of greater collaboration, but we note with some concern that the explanatory notes position this removal as making way for the secretary of state's powers of direction over NHS

England. We are worried that this tendency to centralise and direct will be passed down to ICBs in their leadership and culture. This conflicts with the principle that locally designed systems will best improve patient care and is liable to forcing attention upwards, rather than promoting subsidiarity.

We are concerned that collective confidence in an ICB could be undermined by an excessively top-down approach, which could hinder the opportunity and ambition of system working:

- Schedule 2 states that an ICB chair will be appointed by NHS England with approval from the secretary of state and no involvement of the ICB members or wider system partners. This is concerning as the chair needs to have the confidence of the ICB and system partners. We urge the government to ensure a significant role for these bodies in the recruitment of the chair, even if powers of appointment lie elsewhere.
- The Bill provides for NHS England alone, with approval of the secretary of state, to remove the chair from office. However, it seems probable in the medium term, as local arrangements develop and get underway, that an ICB chair may lose the confidence of the ICB and/or the organisations within the system. Where this happens there must be a role for the ICB board in initiating the removal of the chair and this needs to be addressed in the constitution. If the ICB cannot initiate the removal of the chair, this will potentially lead to conflict, a stalemate and potential disruption to services.
- Schedule 2 makes the appointment of ordinary members subject to the chair's approval. We believe the whole board should approve the appointment of ordinary members (not the chair alone), to maintain the principle of collective responsibility that is central to good governance.

The role of the ICB and its relationship with local health and care bodies

There must be clarity on how the accountabilities of all parts of a local health and care system align without duplication, overlap or additional bureaucracy. For example, some of an ICB's duties as currently set out – such as the duty of quality improvement – risk overlapping with those of trusts. While we agree the board of an ICB will need to be formally accountable to parliament via DHSC and NHS England, the ICB should also see themselves as accountable to the communities they serve and the organisations within their footprint. There should be an obligation on NHS England in the Bill to set this out explicitly in future guidance. In addition, we see that the explanatory notes to the bill state that the ICB will be directly accountable for NHS spend and performance within the system. This does not appear to be explicit within the Bill, however, and we will seek clarity from the government as to the intentions here.

We are pleased to see the reference to ICBs and trusts and foundation trusts jointly developing the system's plan to meet the health needs of their population and jointly setting out how they will

exercise their functions to achieve that plan. We were clear in our discussions with DHSC and NHSE/I that this needed to be a joint endeavour, and we urge the government to extend the principle of co-production to the development of an ICB's composition and constitution. The consultation process for establishing an ICB and drafting an ICB constitution is currently framed as a CCG-led process, and therefore risks lacking appropriate consultation with trusts and wider system partners which would make it more robust. There needs to be a requirement in primary legislation for CCGs, trusts and wider partners to agree the composition and constitution of the ICB, as well as a statutory duty for the ICB to involve system partners in planning and commissioning decisions. There must be a requirement on NHS England to issue statutory guidance which ensures:

- each ICB has a mechanism which enables the views of all trusts to be heard as part of the ICB decision-making process
- each ICB has a robust process for agreeing the ordinary members
- each ICB has a challenge mechanism for trusts, in extremis, to raise concerns to NHS England about the ICB composition, constitution and plans.

We support the government's stated aim in the white paper to reduce the bureaucratic burden on the health and care system, but are concerned about the ever-increasing demands that system working places on trust leaders' time and moreover, that this will happen without any commensurate increase in resources. Taken together with the recent ICS design framework and system oversight framework, the statutory ICB risks creating an additional management and oversight tier rather than taking bureaucratic burden away. We are particularly concerned about how the relationship between trusts and ICBs is framed in the Bill. The clauses describe an ICB as a separate entity to its 'partners', rather than as a genuine partnership of all the organisations that contribute to health and care services and outcomes within the system. This model risks moving away from the founding spirit of partnership and the design principle of the ICS as a sum of its parts, and towards becoming a separate body managing those within it.

Finally, CCGs have largely been repurposed into ICBs. We are concerned that this 'lift and shift' approach to repurposing leaves them open to the charge that the government is simply recreating CCGs on a larger footprint, rather than developing them into a broader strategic, population health planning function. It is clear that the purchaser/provider split is not being fully removed in the Bill, so the link between providers and commissioners in an ICB needs to be sufficiently improved and strengthened by having robust provider input into ICB decision-making.

ICPs and Integrated care system: further amendments (clauses 20 and 25: schedule 4)

Summary

The Bill states that an ICB and relevant LAs must establish a statutory joint committee for the system – an ICP – which will bring together health, social care, public health and wider partners. The ICP membership will include one member appointed by the ICB, one member appointed by each of the relevant LAs, and any other members appointed by the ICP. The ICP will be able to determine its own procedures locally.

The ICP must prepare an ‘integrated care strategy’, building on the relevant joint strategic needs assessments (JSNAs) and considering the effectiveness of establishing section 75 arrangements. The ICP must have regard to guidance issued by the secretary of state. An ICP may include in this strategy a statement of its views on how the provision of health-related services could be more closely integrated with health and social care services. The strategy must detail how it will be delivered by the ICB, NHS England or LAs. There is a requirement for LAs and the ICB, in response and with regard to the integrated care strategy, to create a joint local health and wellbeing strategy.

NHS Providers’ view

We support the lack of prescription around the membership of the ICP on the face of the Bill and the principle of the ICP being a partnership of equals. However, if all relevant LAs, who are already represented in the ICB by a ‘partner’ member, are each involved in setting up the ICP and represented by individual members, without additional provider representation, there will be an inappropriate imbalance when establishing the ICP which undermines the principle of equal partnership.

We support the creation of ICPs as joint committees rather than statutory organisations, and understand the rationale behind a separate body that brings the NHS in England, local government and wider partners together to focus on tackling health inequalities and the wider determinants of health. However, we note that this means an ICP’s functions and duties, and the liabilities that accrue from them, will fall to individual members of an ICP. This may become problematic if an ICP’s functions and duties conflict with the duties and liabilities of these individuals as directors, and there needs to be clarity as to where directors’ duties lie. There also needs to be clarity as the accountability of an ICP and its members in agreeing that strategy.

Integrated care system: financial controls (clauses 21-24)

Summary

These clauses set out the financial responsibilities of NHS England and ICBs. Each ICB must exercise its functions with a view to breaking even. Furthermore, each ICB and its partner trusts and foundation trusts must seek to achieve financial objectives set by NHS England, and operate with a view to ensuring that local capital and revenue resource use does not exceed the limits specified by direction from NHS England in that financial year. NHS England may give directions to an ICB and its partner trusts and foundation trusts to ensure that they do not exceed these limits.

NHS Providers' view

Providers understand how the allocation and distribution of funding at ICB level can make a positive contribution towards the 'triple aim' of better health and wellbeing for everyone, better quality of health services for all individuals, and sustainable use of NHS resources. The 'system first approach' to financial management driven by the response to COVID-19 appears to have been a largely positive experience.

However, it is important to reflect on what has worked well to date, and embed this in legislation (and guidance) to maximise the chances of the new financial regime being a success. As things stand, we are concerned that the Bill does not strike the right balance between embracing the opportunities presented by more collaborative working, and protecting ICBs, trusts and foundation trusts – and ultimately patients – when things do not go as planned. For example, in the event that an ICB, trust or foundation trust feels it has been given an impossible task – say if it is concerned that its funding envelope is insufficient to meet patients' needs, potentially putting outcomes, quality of care and patient safety at risk – it is important that clear routes to recourse exist.

It does not call into question the commitment of any of an ICB's partners to recognise that legislation needs to make provision for those difficult situations which, at times, will be unavoidable as much as partners may regret this. As such, we would welcome the opportunity to work with DHSC and NHS England to explore what a reasonable system of checks and balances might look like. We want to ensure that if and when tensions arise, they can be resolved quickly, fairly and transparently.

Furthermore, we urge the government to give careful consideration to the conditions needed to enable ICBs, and their partner trusts and foundation trusts, to collectively deliver financial balance. This will require an open and honest conversation ahead of the Comprehensive Spending Review

about the funding needed to fully recover from COVID-19, transform the NHS, and build greater resilience into the wider health and care system.

Merger of NHS bodies (clauses 26-32; schedule 5)

Summary

Clause 26 abolishes Monitor, with schedule 5 making consequential amendments relating to the transfer of Monitor's functions to NHS England. This fulfils the intention of DHSC to merge Monitor into NHS England to form a single body. Clause 27 places a duty on NHS England to minimise the risk of conflict between its regulatory and other functions, and managing any conflicts that arise. Clause 28 adds to current provisions to require an impact assessment before modification of standard licence conditions in all providers' licences or in licences of a particular description is allowed. Clause 29 transfers powers from the Trust Development Authority (TDA) to NHS England and abolishes the TDA.

NHS Providers' view

Overall, we support the move to merge Monitor and the TDA into NHS England and welcome the consistency and clarity it will offer. However, we note this raises a series of questions for the new NHS England as a single organisation that concurrently sets the national policy framework, supports improvement, and acts as a regulator. The merger removes the inherent tension deliberately created by the Health and Social Care Act 2012 which replicated a commissioner/provider split at a national level, and consolidates the direction of travel with NHS England seeking to operate as a more integrated body. However, while the Bill contains some useful provision for NHS England to manage conflicts of interest, this does not negate the fact that NHS England will be required to oversee and regulate the outcome of its own decisions. We will continue to work with DHSC and NHS England to understand the implications of this change in practice and what further safeguards may be needed to account for potential conflicts of interest between NHS England's various functions and powers.

Secretary of state's functions (clauses 33-38; schedule 6)

Summary

These clauses set out a number of powers of direction for the secretary of state, including in relation to public health, NHS England, safety investigations and reconfiguration. A duty on the secretary of state regarding publication of an assessment of the workforce needs of the health service in England is also set out.

Key clauses and NHS Providers' view

Clause 33: Report on assessing and meeting workforce needs

This clause sets out a duty on the secretary of state to publish, at least once every five years, a report describing the system for assessing and meeting the workforce needs of the health service in England. It also places a duty on Health Education England (HEE) and NHS England to assist the secretary of state in preparing the report, if asked by the secretary of state to do so.

NHS Providers' view

The intent of this clause is to add clarity and transparency on roles and responsibilities within the NHS on workforce planning. This is a welcome step forward and acknowledgement of the multiple bodies involved in this work. However, this duty will also essentially act to set out the status quo. The NHS desperately needs a long-term workforce numbers plan setting out the desired future shape and size of the workforce. We have called for an additional duty in the Bill to ensure the development of regular, public, long-term workforce projections drawing on input from all relevant NHS arm's length bodies, NHS frontline organisations such as ICBs and trusts, and expert bodies such as think tanks. These projections should set out, independently from ministers, on an arm's length basis, the size and shape of the future workforce needed to deliver safe, effective, high-quality care and the estimated cost of delivering this workforce. There should then be a duty on the secretary of state to regularly update parliament, more than once a parliament, on the government's strategy to deliver those long-term projections, including its approach to providing the required funding.

Clause 34: Arrangements for exercise of public health functions: arrangements; and clause 35: Power of direction: public health functions

Clause 34 allows for any of the secretary of state's public health functions to be exercised by NHS England, an ICB, a LA that has duties to improve public health, a combined authority, or any other body that is specified in regulations. Clause 35 allows the secretary of state to direct NHS England or an ICB to exercise any of the public health functions of the secretary of state, and provides for funding in relation to the functions to be exercised.

NHS Providers' view

Existing legislation enables the secretary of state to delegate public health functions by agreement. As part of this, NHS England currently commissions a range of services, including national immunisation and screening programmes. However, the secretary of state cannot require NHS England or any other NHS body to take on a delegated public health function, which may mean that the secretary of

state will be unable to deliver an aspect of their duties. The proposed clause in the Bill provides the secretary of state with greater flexibility as to which body carries out public health functions.

We support the introduction of flexibility for the secretary of state to direct NHS England to carry out delegated public health functions. We have previously highlighted the challenges associated with the LA commissioning of certain clinical public health services including health visiting, sexual health services and drug and alcohol services. Fragmentation and underfunding of services have undermined the ability of trusts, who are frequently commissioned to provide these services, to effectively deliver services and meet the needs of local communities. These services would be better placed to sit within the NHS and be commissioned alongside other clinical services, and so we welcome the opportunity for NHS England to play a greater role in commissioning services.

While we support this proposal, changes to the delegation of public health functions must not be considered as a cure-all for challenges faced by public health. Underfunding of services will continue to present challenges, regardless of who is delivering services. Should any future proposal be brought forward under this power, we would emphasise the need for it to be subject to full and wide consultation with a range of partners both within and outside the NHS.

Clause 36: Power of direction: investigation functions

Clause 36 enables the secretary of state to direct NHS England (if they consider it in the public interest) or any other public body to exercise any of the investigation functions which are specified in the direction. The 'investigation functions' here are those carried out by the Healthcare Safety Investigation Branch (HSIB) under ministerial directions relating to its investigative functions and its additional investigative functions in respect of maternity cases.

NHS Providers' view

Further clarity on this clause and how it works alongside Part 4 of the Bill and the work that the HSSIB would undertake would be welcome. In particular, it would be helpful to understand the intended approach to the maternity investigations currently undertaken by the HSIB. The HSIB has had a valuable role in identifying how NHS providers can sustainably and systematically improve the quality of their maternity investigations and then appropriately support those providers to make the required improvements. However, it remains important for these investigations to return to the NHS at an appropriate point to ensure proper accountability, to support a trust's relationships with the affected families and staff, and to avoid the loss of skill within the NHS in carrying out such investigations. We also note that the explanatory notes state, 'the Bill will establish a new statutory body which will largely replace the Investigation Branch', and we will seek clarification as to the intent there.

Clause 37: General power to direct NHS England

Clause 37 gives the secretary of state the power to direct NHS England in relation to their functions. There are exceptions to this power – the secretary of state cannot use the power in relation to the appointment of individuals by NHS England (including trusts and foundation trusts), individual clinical decisions, or in relation to drugs or treatments that the National Institute for Health and Care Excellence (NICE) have not recommended or issued guidance on as to clinical and cost effectiveness.

NHS Providers' view

This is a key provision to note as it appears to signal a recentralisation of power and to open up the possibility of ministers' involvement in aspects of the operational management of the health service. We are concerned that without appropriate safeguards in place, decisions might be reached based on political motivation rather than focused on the best interests of services and populations. The clinical and operational independence of the NHS must be maintained to ensure equity for patients within the service, best use of constrained funding, and clinical leadership with regard to prioritisation and patient care. We are concerned that there are no protections to mitigate against the involvement of the secretary of state in the day-to-day running of the NHS. This could arguably expose the government, any secretary of state, the service and patient care to undue, unmanaged risk.

The clause indicates that a direction must include a statement that the secretary of state considers the direction to be in the public interest and that this should be published as soon as is reasonably practicable. We are concerned that the way in which the 'public interest test' has been drafted is a subjective test, applied by the secretary of state. This could leave the secretary of state able to intervene in individual funding allocations. We believe there needs to be further discussion about whether such broad powers are necessary and proportionate, and would also encourage setting out specific criteria that must be met and a 'public interest test' for the deployment of these powers.

Clause 38: Reconfiguration of services: intervention powers; and schedule 6

Clause 38 gives the secretary of state intervention powers in relation to the reconfiguration of NHS services. Arrangements are detailed in schedule 7, which places a duty on an NHS commissioning body (that is, NHS England or an ICB) to notify the secretary of state when there is a proposal to reconfigure services. It also places a duty on an NHS commissioning body, NHS trust or foundation trust to notify the secretary of state when a reconfiguration is considered likely to be needed. The schedule gives the secretary of state power to give a direction calling in any proposal for the reconfiguration of services. The secretary of state can then take on the decision-making role of the NHS commissioning body concerned (for example, whether a proposal should proceed or not or whether the proposal should be modified). It also allows for the secretary of state to retake any

decision previously taken by the NHS commissioning body. When the secretary of state has made a decision, they must publish any decision made about a reconfiguration and notify the NHS commissioning body concerned of the decision.

NHS Providers' view

This gives wide ranging powers to the secretary of state to direct local service reconfigurations, and does so without appropriate safeguards. Decisions on local service reconfigurations are best taken locally by the organisations that are accountable for those services following meaningful engagement with local communities. While clarity and speed can be welcome in making such decisions, this should not be at the expense of local engagement and decision-making. The proposed powers risk undermining local accountability in the NHS, and local authority overview and scrutiny committees. They do not necessarily protect the best interests of patients and run the risk of political interference in the provision of local NHS services. In order to ensure that this power does not adversely affect services and patient care we believe that the following principles should be applied and set out on the face the Bill:

1. Any secretary of state involvement should be fully transparent, with the right of the affected parties to make appropriate representation and the secretary of state's intervention made against set, public, criteria
2. There is an appropriate role for an independent body like the Independent Reconfiguration Panel to provide independent advice on detailed issues including the validity and importance of the clinical case for change
3. There should be an appropriate threshold governing the level of reconfiguration where the secretary of state is involved
4. There should be an explicit test that use of the power must maintain or improve safety before it can be exercised.

NHS trusts (clauses 39-50; schedule 7)

Summary

A number of clauses in this chapter repeal redundant legislative sections, including some legislation which were never commenced – one example is provision in the Health and Social 2012 Act for the formal abolition of NHS trusts which was never commenced because the foundation trust pipeline was not completed as initially envisaged. This set of clauses also removes the power of the secretary of state to appoint trustees for an NHS trust to hold property on trust.

Clause 42 removes the exemption on NHS trusts to hold a licence from NHS England and requires NHS England to treat any new NHS trusts as if they had applied for a licence – effectively bringing the provider licence in line with the approach for foundation trusts.

Clause 43 sets out a new duty, which applies to ICBs, NHS England and foundation trusts and trusts in England (the 'relevant bodies'). This duty has been described by DHSC operationally as the 'triple aim' duty. ICBs and trusts will be under a duty when carrying out their functions, to have regard to all likely effects of their decisions on:

- the health and wellbeing of the people of England
- the quality of services provided or arranged by relevant bodies
- the efficiency and sustainability of resources used by the relevant bodies.

Decisions relating to services provided to a particular individual (for example individual clinical decisions or highly specialist commissioning decisions concerning an individual patient) are exempt from this duty.

Clauses 44 to 47 and clause 49 effectively give NHS England existing powers previously held by the TDA (and/or the secretary of state) over NHS trusts. Clause 49 gives NHS England the power to appoint the chair of an NHS trust, replacing the secretary of state's power here.

Clause 48 means that an application by an NHS trust to become a foundation trust no longer requires the support of the secretary of state. However, authorisation may only be given for foundation trust status if the secretary of state approves the authorisation and NHS England is satisfied. This clause also gives NHS England the power to dissolve a trust on the approval of the secretary of state and allows NHS England or the secretary of state to make the order for dissolution, if either consider it appropriate to do so. Neither the secretary of state nor NHS England may make a dissolution order until after the completion of a consultation unless as a matter of urgency or following the publication of a final report from a trust special administrator.

Clause 50 amends existing legislation such that NHS England, rather than the secretary of state with the consent of HM Treasury, may set financial objectives for trusts. As is the case now, trusts must achieve these objectives. Furthermore, objectives may apply to trusts generally, or to a particular trust or trusts of a particular description.

NHS Providers' view

For the most part, our understanding of this group of clauses is that it 'tidies up' existing legislation in line with the proposed direction of travel under a single, statutory NHS England – dealing in particular with the consequences of the merger of TDA with NHS England. It reinforces some degree of equalisation between trusts and foundation trusts in terms of the application of the provider licence.

We are interested to see that the legislation leaves open the potential for NHS trusts to seek and secure foundation trust status. While we understand this is more of a convenience within the Bill than a policy expectation, we will of course explore this further with DHSC and NHSE/I colleagues.

Trust leaders will be interested to review the proposed clauses on the new 'triple aim' duty which will apply to ICBs, trusts and the new NHS England. Our views are set out above (see clause 4), and we would welcome feedback on the anticipated practical impact of this clause on your trust and ICB. While the amendments to clause 50 are relatively minor, the clause needs to be viewed within the context of the wider changes to financial arrangements outlined in the bill (specifically clauses 21-24 on ICS financial controls, and clause 66 and schedule 10 on the NHS payment scheme). At this stage, it is unclear how the clause will be implemented in practice – for example, the consequences that will be associated with a trust's failure to achieve its financial objectives. This is something we are urgently seeking clarity on.

NHS foundation trusts (clauses 51-57)

Summary

Clause 52 gives NHS England the power to set a capital expenditure limit on a foundation trust. Therein, NHS England has the power to establish an order to set a capital expenditure limit on a foundation trust for a defined period for which the order relates. It places a duty on NHS England to consult with the foundation trust before the order is made and requires NHS England to publish the order. The clause further imposes a statutory duty on the foundation trust not to exceed the capital expenditure limit, and sets the definition for capital expenditure in line with how capital is reported in the foundation trusts annual accounts. NHS England must produce guidance on the use of its power to make orders, and NHS England is required to consult with the secretary of state before publication of such guidance. The guidance will set out information about the circumstances in which NHS England is likely to make an order to set a capital expenditure limit for a foundation trust and how it will establish the limit. NHS England must have regard to the guidance when deciding whether to issue any orders to limit capital expenditure by foundation trusts, and to keep the guidance under review.

Clause 54 will allow an NHS foundation trust to carry out its functions jointly with another organisation. The Bill will create a new legal mechanism that will allow ICBs and NHS providers to form joint committees, or two or more providers, to make joint arrangements and pool funds. Guidance will also be issued on joint appointments. Parallel measures in the Bill will also make it easier for ICBs to commission services collaboratively with other ICBs and other system partners by permitting a wider set of arrangements for joint commissioning, pooling of budgets and delegation of functions.

The other clauses here amend existing legislation in line with the creation of a single merged NHS England and seek to streamline licensing and parts of the transactions process. In summary:

- Clause 51 means NHS England can treat existing foundation trusts and new foundation trusts created via merger as having applied and been granted a licence
- Clause 53 means that foundation trusts will send their forward plans to NHS England rather than Monitor. Other amendments allow for greater flexibility on how accounts are to be prepared.
- Clause 55 removes the requirement that an application to merge a foundation trust with an NHS trust must be supported by the secretary of state. This clause would also place a duty on NHS England to grant the application if it was satisfied that necessary steps have been taken to prepare for the dissolution and the establishment of the new trust and the secretary of state approves the grant of the application. An application to acquire a foundation trust or a trust similarly no longer requires the support of the secretary of state. This clause introduces a new duty on NHS England to grant the application if it is satisfied that necessary steps have been taken to prepare for acquisition and the secretary of state approves the grant of the application.
- Clause 56 removes the requirement for the grant of an application made by a foundation trust for dissolution to be based on the trust having no liabilities as currently set out in the National Health Service Act 2006. NHS England will also be required once the application for dissolution has been granted, to transfer, or provide for the transfer of, the property and liabilities (including criminal liabilities) to another foundation trust, a trust, or the secretary of state. It also imposes a duty on NHS England to include in the order a provision for the transfer of any employees of the dissolved foundation trust.
- Clause 57 reflects and reiterates the new 'triple aim duty'.

NHS Providers' view

We have significant concerns regarding the clause on capital spending limits for foundation trusts. The clause in the Bill does not mirror NHS England and NHS Improvement's September 2019

legislative proposal which was the result of detailed negotiations with NHS Providers on behalf of our foundation trust members. The clause also cuts across the [Health and Social Care Committee's unequivocal position](#) that the power to set capital spending limits for foundation trusts 'should be used only as a last resort'. We will ask parliament to consider adding the following safeguards to the Bill, which were agreed between NHS Providers and NHS England and NHS Improvement in 2019:

1. The power to set capital spending limits for foundation trusts should be circumscribed on the face of the Bill as a narrow reserve power;
2. Each use of the power should apply to a single named foundation trust individually;
3. Each foundation trust's capital spending limit should automatically cease at the end of the current financial year;
4. NHS England should be required to explain why use of the power was necessary, describe what steps it has taken to avoid requiring its use and include the response of the foundation trust when publishing each order; and
5. There should be a requirement for each order to be published in parliament, to ensure maximum transparency.

NHS trusts and NHS foundation trusts: transfer schemes between trusts (clause 58)

Summary

This allows for NHS England to make one or more schemes to transfer property, rights and liabilities from a relevant NHS body to another relevant NHS body, such as an NHS trust or an NHS foundation trust. The clause allows NHS England to set out what steps need to be taken before an application can be granted and what should be included in the scheme.

NHS trusts and NHS foundation trusts: Trust special administrators: (clause 59; schedule 8)

Summary

This outlines the changes to the process and authorisation for the appointment of trust special administrators, including reporting mechanisms.

Joint working and delegation of functions (clauses 60-61; schedule 9)

Summary

This enables NHS England, ICBs, trusts and foundation trusts to exercise their functions jointly with each other and/or local authorities. It also enables trusts and foundation trusts to establish joint committees and pooled funds with other trusts, foundation trusts, NHS England and ICB(s), and/or LAs. NHS England may publish guidance for NHS bodies in relation to joint working and delegation arrangements.

Collaborative working (clauses 62-65)

Summary

Clause 62 removes the secretary of state's and NHS England's duties to promote autonomy. NHS England will continue to function as an arm's length body. The removal of this duty is to allow for the introduction of clause 36 (directions to NHS England) which gives the secretary of state the ability to direct NHS England in regard to the exercise of its functions.

Clause 63 gives NHS England the ability to issue guidance concerning joint appointments between one or more NHS commissioner and one or more NHS providers; between one or more NHS body and one or more LA, or one or more NHS body and one or more combined authority. References here to NHS bodies mean NHS England, ICBs, trusts and foundation trusts. Ahead of publishing or revising any guidance, NHS England will be required to consult with appropriate organisations.

Clause 64 introduces a new power for the secretary of state to make guidance on how the duty imposed on NHS bodies to co-operate with each other is discharged. It also imposes a duty on NHS bodies, except for Welsh NHS bodies, to have regard to this guidance. This clause also creates new powers which will impose a duty on NHS bodies and LAs (including Welsh NHS bodies and Welsh LAs) to co-operate with one another in order to advance the health and welfare of the people of England and Wales. It also inserts a new power for the secretary of state to make guidance related to England, and imposes a duty on NHS bodies and local authorities, except for Welsh NHS bodies and Welsh local authorities, to have regard to this guidance.

Clause 65 amends the 2012 Act to specify the purposes for which Monitor (which this Bill proposes to merge with NHS England) may set or modify the conditions contained in the licences which any provider of health care services for the purposes of the NHS must hold. In light of the creation of the 'triple aim' duty for NHS England, ICBs, foundation trusts and trusts, a new purpose for which licence conditions may be set or modified is being created, namely that of ensuring that decisions are

made with regard to all of their likely wider effects on the three factors which are included in the new 'duty to have regard to the effect of decisions'.

NHS Providers' view

NHS Providers supported NHS England's initial proposal in 2019 for a new 'duty to collaborate' in support of the aims of system working. We will seek views from DHSC colleagues as to whether the current wording of a 'duty to co-operate' materially alters the intent of these clauses in any way.

We note that clause 62 explicitly removes duties on the secretary of state and on NHS England to 'promote autonomy'. This reflects proposals elsewhere in the Bill to alter the relationship between the secretary of state and NHS England. Our position on the need to place much greater safeguards around many of the proposals on new powers of direction for the secretary of state are made elsewhere in this briefing. However, it is also worth noting that clause 62 similarly removes NHS England's duty to promote autonomy. Although this is in line with the direction of travel for trusts and their partners as they embed more collaborative arrangements within local systems (and sits in contrast to the 2012 Act which actively promoted competition) we will continue to argue strongly for the need for clear lines of accountability within the system, including clear lines of accountability from trust boards for the quality of care they deliver, and as large employers. In our view organisational autonomy can exist alongside collaboration and co-operation.

NHS payment scheme (clause 66; schedule 10)

Summary

Clause 66 and schedule 10 replace the national tariff with the NHS payment scheme and make provisions relating to the new scheme. The scheme will be published by NHS England, which will consult with ICBs and relevant providers across the NHS and independent sector. The scheme will set rules around how commissioners establish prices to pay providers for healthcare services for the purposes of the NHS, or public health services commissioned by an ICB or NHS England, on behalf of the secretary of state. The intention is to give the NHS more flexibility in how prices and rules are set, in order to help support more integrated care at local levels.

Key clauses and NHS Providers' view

Schedule 10, paragraph 114D

Paragraph 114D deals with objections to the NHS payment scheme. The key difference to the existing statutory objection process for the national tariff is that the Competition and Markets Authority (CMA)

will no longer have a role in reviewing objections. Instead, NHS England will make its own decisions about how to proceed. If it decides to make amendments that are, in its opinion, significant and unfair to make without further consultation, it must consult ICBs and relevant providers again. If it decides not to make amendments, it may publish the NHS payment scheme alongside a notice stating that decision and setting out the reasons for it.

NHS Providers' view

The introduction of the NHS payment scheme represents a move away from mandatory national prices for many services to commissioners having a greater say over the prices they pay providers. Trusts generally support this direction of travel and welcome the opportunity to have more open conversations about the true cost of providing services. We are working with NHSE/I to ensure that trusts' views are properly considered in the design of the NHS payment scheme (and that the benefits associated with the national tariff are not lost).

At the same time, we are concerned that the changes proposed appear to represent a cumulative loss of independent oversight, particularly with the removal of the CMA as a route to recourse. This could potentially increase the risk of an unworkable NHS payment system being imposed on ICBs and their constituent organisations. We would welcome the opportunity to work with DHSC and NHSE/I to ensure that the right checks and balances are enshrined in law.

Patient choice and provider selection (clauses 67-69; schedule 11)

Summary

These clauses revoke existing procurement and competition requirements. They also strengthen the current rules around patient choice by making it mandatory for regulations to contain provisions about how NHS England and ICBs will allow patients to make choices about their care, and provide NHS England with new powers to enforce patient choice requirements. The intention is to pave the way for a new NHS provider selection regime that moves away from competitive retendering by default in favour of a more collaborative approach to planning and delivering services.

NHS Providers' view

We support the intention behind NHSE/I's proposals for a new NHS provider selection regime as we agree that the current rules for procuring healthcare services can unnecessarily disrupt the provision of high-quality local services and impede effective planning over the longer term. We understand why the legislative changes put forward in the Bill are necessary. However, more broadly, we have questions and concerns about how the regime will operate transparently and robustly in practice, and

believe that the inclusion of an appropriately defined challenge function would be beneficial. More detail can be found in our [April 2021 response](#) to NHSE/I's consultation. We are continuing to engage with NHSE/I as the regime develops and will keep members updated on our work in this area.

Competition (clauses 70-73; schedule 12)

Summary

Clause 70 proposes to require NHS England to give the CMA regulatory information that the CMA may need to exercise its functions, or which would assist it in carrying out its functions. This includes information held by NHS England relating to patient choice, and oversight and support and recommendations about restructuring.

Clause 71 introduces an exemption from Part 3 of the Enterprise Act 2002, removing CMA powers over trust mergers. Instead, NHS England, as the national body responsible for the NHS, will review mergers of NHS providers to ensure they are in the best interests of patients and the taxpayer.

Clause 72 also removes Monitor's competition duties ahead of the merger with NHS England to allow NHS England to focus more on improvement in the quality of care and use of NHS resources, and on the development of integrated care.

Clause 73 will remove Monitor's ability to refer contested licence conditions and tariff prices to the CMA. Instead, NHS England will make its own decisions on how to operate the licensing regime and the NHS payment scheme, in consultation with local leaders.

Miscellaneous (clauses 74-78)

Summary

Clause 75 sets out requirements for Special Health Authorities (SpHAs) in relation to their accounts and auditing. Clause 76 repeals the powers of the secretary of state in the 2012 Act to make a property transfer scheme or a staff transfer scheme in connection with the establishment or abolition of a body by the 2012 Act, or the modification of the functions of a body or other person by or under that Act.

Clause 77 abolishes Local Education and Training Boards (LETBs).

Clause 78 revokes section 74 of the Care Act 2014 and schedule 3 of the Care Act 2014. Schedule 3 in the 2014 Act deals with the planning of discharge of patients in England from NHS hospital care to LA care and support. In revoking schedule 3 here, the procedural requirements which require social care needs assessments to be carried out by the relevant LA before a patient is discharged from hospital are repealed. It also repeals provisions which enable the responsible NHS body to charge the relevant LA via a penalty notice, where a patient's discharge from hospital has been delayed due to a failure of the LA to arrange for a social care needs assessment, after having received an assessment and discharge notice for an individual from the relevant NHS body.

NHS Providers' view

The abolition of LETBs to an extent formalises existing practice given that they have been progressively reduced in number and in importance in recent years. LETBs have ceased to be used as the primary vehicle for collaborative conversations within areas and regions on local education and training needs, and workforce planning more generally. Their function has been partly replaced by the recent establishment of regional people boards, set up by HEE and NHSE/I. Most regional people boards are chaired by or have a significant representation of trust leaders, which should help to ensure the flow of local intelligence on workforce needs and planning into discussions. However, it remains to be seen how local and ICB and system level discussions around workforce planning are managed within and outside these forums. We also note the need for any local changes to be supported by a fully funded long-term workforce plan.

It is important that arrangements to replace the function of LETBs – including through the establishment of regional people boards – do not repeat the mistakes made by the Care Act's excessive centralisation of local workforce planning functions. The original rationale for establishing LETBs had been to "build a system that is responsive to the needs of employers, the public and the service at local level". It is important this remains the aim, with an emphasis placed on the ability of trusts and other local actors to provide the intelligence required for effective workforce planning and commissioning of education and training. Providers are best placed to identify current and future resource gaps, and their continuing and growing input here is vital to establishing a rigorous and realistic evidence base.

Part 2: Health and adult social care: information

Clauses 79-85

Summary

The data provisions in the Bill are intended to work collectively to enable increased sharing and more effective use of data across the health and adult social care system. The general duties of the Health and Social Care Information Centre (the Information Centre; known as NHS Digital) will be amended so that it may only share information for purposes connected with the provision of health care or adult social care or the promotion of health. The Information Centre will be able to require private providers of health services to provide any information it requires in order to comply with a direction from the secretary of state. Other provisions enable the secretary of state to require certain providers of adult social care services to provide information relating to themselves, their activities in connection with providing adult social care in England, or individuals they have provided adult social care to in England or, where those services are commissioned by a LA in England, or outside England. There are also powers to enforce information provisions against private providers, as well as provisions that confer a delegated power on the appropriate authority to make regulations providing for a system of information in relation to medicines to be established and operated by the Information Centre, and specifying the type of provision which can be included in the regulations.

NHS Providers' view

We welcome the ambitions behind the proposals to facilitate greater sharing of information across health and care providers. Any policy or legislative proposals that clarify data sharing parameters for people will undoubtedly improve the pace of change. Improving data quality, access and flows will underpin three core NHS long term plan aims: moving to population health management, progressing the prevention agenda, and tackling health inequalities. There will also be gains in terms of patient safety and improved efficiency.

We recognise that the response to the COVID-19 pandemic has accelerated digital ways of working but with this increased use of digital technologies comes a renewed focus on interoperability. Interoperable systems improve the delivery of health and care, ensuring that clinicians have access to the right information at the right time. Greater interoperability will also underpin the integrated care agenda and help deliver shared care records across integrated care systems.

However, we are concerned that these legislative proposals do not address the underlying issues of bureaucratic burden around data collections in the health and care system. Data requests and record

management are constantly cited as the primary bureaucratic burden on staff of all types. Data requests from regulators, commissioners and the national bodies should be proportionate and have a direct link to improving care. The proposals seem to increase the reporting burden on providers rather than decrease them as per the white paper intentions, and it will be important to ensure that reporting is not used as a command and control tool.

Many trusts as well as other health and care providers need investment to improve their technical infrastructure, as data is only as good as the technical flows an organisation's infrastructure is capable of. Consideration therefore needs to be given as to the support and investment required here and the implications for implementation. Moreover, we are concerned to ensure an aligned approach to the digital agenda.

Part 3: Secretary of state's powers to transfer or delegate functions

Clauses 86-92

Summary

These clauses give the secretary of state powers to make regulations to confer a function on a body; abolish a function of the body; change the purpose or objective for which the body exercises a function; and change the conditions under which the body exercises a function. The bodies in question here are HEE, the Information Centre, the Health Research Authority, the Human Fertilisation and Embryology Authority (HFEA), the Human Tissue Authority and NHS England.

NHS Providers' view

Of particular note here is clause 87, which would allow the secretary of state to transfer functions between bodies. The secretary of state may not change functions in a way so as to make NHS England redundant but they can abolish the other bodies by regulation. The power to abolish a body such as the HFEA, or the power to transfer the majority of their powers to other bodies, requires proper parliamentary scrutiny. We believe that such changes should require primary legislation.

Part 4: The Health Services Safety Investigations Body

Clauses 93-119; schedules 13, 14 and 15

Summary

Part 4 of the Bill puts the Health Services Safety Investigations Body (HSSIB) on a statutory footing. The organisation is currently established as the Healthcare Safety Investigation Branch (HSIB) under ministerial directions as part of the TDA and hosted by NHS Improvement. Schedule 13 describes the constitution of the HSSIB, including the appointment of the chief investigator and funding. Schedule 14 describes the exceptions to prohibition of disclosure of protected material. Schedule 15 contains consequential amendments relating to Part 4.

NHS Providers' view

NHS Providers strongly supports the principle of creating the HSSIB as an independent statutory entity and enabling it to conduct safe space investigations so that the NHS can improve patient care and learn from when things go wrong. Organisational cultures that support staff to speak up have higher levels of staff engagement and patient satisfaction and are associated with reduced errors in care and better safety. In 2019, the Health Service Safety Investigations Bill was published but did not progress through parliament. We are pleased to see a number of helpful revisions to those earlier provisions within this part of the Bill. Nevertheless, we are concerned to ensure that the Bill provisions genuinely enable the HSSIB's independence – crucial to its ability to carry out its intended systemic safety role – and protect the integrity of safe space.

Key clauses and NHS Providers' view

Clause 95: Deciding which incidents to investigate

Under Clause 95, the HSSIB determines which qualifying incidents it will investigate, but this is subject to the secretary of state's power to direct the HSSIB to carry out an investigation of a particular qualifying incident or qualifying incidents of a particular description. The secretary of state's directions must be in writing, and may be varied or revoked by subsequent directions, and they may provide for a person to exercise discretion in dealing with any matter.

NHS Providers' view

The parliamentary joint committee on the Draft Health Service Safety Investigations Bill in 2018 made clear the importance of the HSSIB's independence of judgement in deciding what investigations it undertakes. We note that a direction "may provide for a person to exercise discretion in dealing with any matter", but this does not seem to be a sufficiently strong safeguard. If the secretary of state is to

be able to direct the HSSIB to carry out an investigation, then three explicit balancing provisions are needed to maintain the HSSIB's independence. Firstly, it must be able to decline to carry out the investigation where there is reasonable justification. Secondly, adequate funding must be made available to the HSSIB to enable it to carry out such investigations in order to avoid compromising its ability to carry out its investigative function as the HSSIB would otherwise determine. Thirdly, the continuing independence of the HSSIB in how it carries out any such investigation and the independence of its consequent recommendations is paramount and should be explicitly protected.

Clause 106: Prohibition on disclosure of HSSIB material; clause 107: Exceptions to prohibition on disclosure; and schedule 14

Clause 106 sets out prohibitions on disclosure of HSSIB material. The HSSIB, or an individual connected with the HSSIB (past or present), must not disclose protected material to any person. "Protected material" means any information, document, equipment or other item which is held by the HSSIB or a connected individual for the purposes of the investigation function, and which relates to a qualifying incident, and which has not already been lawfully made public.

Clause 107 sets out exceptions to the prohibition on disclosure. Prohibitions do not apply to a disclosure which is required or authorised by schedule 14 (see below), other provisions within part four of the Bill, or regulations made by the secretary of state (for example, by reference to the kind of material, the matters to which it relates, the person from whom it was obtained, the purpose for which it was produced or is held, or the purpose for which it is disclosed). Regulations may provide for a person to exercise discretion in dealing with any matter.

Schedule 14 describes the exceptions to prohibition of disclosure of protected material. This includes the HSSIB disclosing protected material to a person if the chief investigator reasonably believes it necessary:

- for the purposes of the carrying out of the HSSIB's investigation function
- for the purposes of the prosecution or investigation of an offence relating to investigations or to unlawful disclosure
- to address a serious and continuing risk to the safety of any patient or to the public; if it is reasonably believed that the person is in a position to address the risk; and if the disclosure is only to the extent necessary to enable the person to take steps to address the risk.

A person may apply to the High Court for an order that any protected material be disclosed by the HSSIB to the person for the purposes specified in the application (which can include onward disclosure). The HSSIB may make representations to the High Court about any application. The High Court may make an order on an application only if it determines that the interests of justice served by

the disclosure outweigh (a) any adverse impact on current and future investigations by deterring persons from providing information for the purposes of investigations, and (b) any adverse impact on securing the improvement of the safety of health care services provided to patients in England. Similar provisions apply for senior coroners to make applications for disclosure and onward disclosure.

NHS Providers' view

There is a wide body of research that evidences the importance of work environments that offer 'psychological safety' for staff to discuss in a confidential setting the circumstances of an incident that has resulted in avoidable harm. It is through a robust application of a safe space that the HSSIB will be able to command the confidence of participants and best understand the safety risks present and make appropriate recommendations.

However, there seems to us a risk in the current drafting that the exceptions on prohibition of disclosure are wide ranging, discretionary and unreasonably open to external applications for access. For example, the impact assessment published for the previous HSSI Bill in 2019 noted that, "Litigation in healthcare is a more frequent occurrence than in other areas of accident investigation. It is therefore possible that lawyers representing patients or NHS staff involved in safety incidents that have been investigated by HSSIB, may make applications for disclosure of 'safe space' information hoping to uncover material of benefit to their clients". The High Court's balancing test seems liable to be intrinsically balanced towards considerations of legal justice rather than systemic patient safety or learning, not least as the ability of the High Court to consider disclosure as potentially deterring information provision is questionable given that the HSSIB has powers to compel interviews and information provisions. With multiple avenues of information and powers of investigation – as well as the HSSIB's final reports being available – other bodies do not need access to protected material simply thanks to the convenience of the HSSIB's existence. As the [joint committee](#) concluded: "We recommend that the draft Bill be amended to put beyond any possible doubt that the 'safe space' cannot be compromised save in the most exceptional circumstances, and therefore that the prohibition on disclosure applies equally to disclosure to coroners".

We will seek articulation during debates in Parliament as to how the government expects these provisions to work, with examples of where disclosure may take place and the level of where the bar is set in considering disclosure. We will also seek a tighter drawing of the boundaries of safe space to ensure its appropriate preservation and in turn support participants in playing their full role in an investigation. We would suggest for example that the tests for an application to disclose protected materials must be sufficiently strong to ensure that disclosure is only sought in extremis, that there is a clear and overriding public interest in any disclosure, that the anonymity, safety and privacy of

participants is respected without exception, and that current and future investigations are not jeopardised.

Part 5: Miscellaneous

Clauses 120-129; schedule 16

Summary

Part 5 covers a range of issues. Clause 120 sets out proposals on international healthcare arrangements intended to enable the government to implement more comprehensive reciprocal healthcare agreements with Rest of World countries, subject to negotiations. Also included is a new duty on the Care Quality Commission (CQC) to conduct reviews, assess performance and publish reports on the exercise of regulated care functions by English LAs relating to adult social care and providing financial assistance to social care services. Clauses here also enable changes to be made to the professional regulation system; restrict the advertising of certain food and drink products; set minimum standards for food and drink in hospital settings; make regulations regarding food information and labelling; and introduce powers for the secretary of state to introduce, terminate or vary water fluoridation schemes.

Key clauses and NHS Providers' view

Clause 121: Regulation of local authority functions relating to adult social care

Clause 121 clause sets out a duty for the CQC to conduct reviews, assess performance and publish reports on the exercise of regulated care functions by English LAs relating to adult social care. The secretary of state will set objectives and priorities for CQC's assessments. Under the proposals, CQC would be required to set and publish indicators of quality to assess LAs' performance and prepare a statement setting out the frequency of reviews and a methodology for assessing LAs' performance, with flexibility to set different indicators, objectives and priorities for different cases. The secretary of state will have powers to direct CQC to revise its quality indicators, assessment framework, and frequency and methodology for different cases.

NHS Providers' view

We are broadly supportive of the duty for the CQC to conduct reviews, assess performance and publish reports on the exercise of regulated care functions by English LAs relating to adult social care. However, we note that this would involve the CQC becoming involved in assessing commissioning and administrative activity, potentially taking it away from its core remit of assessing the quality of services. In addition, we have questions around how the CQC would assess an LA's performance, how

they would define the link between an LA's activity and the quality of local services, and what impact these assessments would have on the quality of services being delivered.

Clause 122: Provision of social care services: financial assistance

Clause 122 enables the secretary of state to give financial assistance to bodies engaged in social care provision or connected services. The secretary of state may direct an NHS trust or an SpHA to exercise any of the functions of the secretary of state in relation to this financial assistance.

NHS Providers' view

This clause seeks to remove bureaucratic barriers to providing rapid financial support to a social care provider sector in exceptional circumstances, as seen during the COVID-19 pandemic. Currently, the secretary of state can only make such direct payments to not-for-profit bodies, so this clause expands existing powers to allow direct payments to be made to social care providers in England.

While we recognise the drivers behind the proposal in the Bill to provide financial support to the social care provider sector at speed in emergency scenarios, we do not think that the current Bill is the right legislative mechanism. We believe instead these powers should be incorporated into the relevant emergency legislation as temporary provisions with appropriate safeguards. We are concerned about the unintended consequences of establishing the secretary of state as a potential direct commissioner of social care providers. This risks undermining LAs' commissioning role and their knowledge of the local provider market. We are also concerned about the power it gives secretary of state to direct trusts and SpHAs to make payments to social care providers, and we do not support this approach and the implication that funding may be required from trusts.

Clause 123: Regulation of health care and associated professions

Clause 123 enables changes to be made through secondary legislation to the professional regulation system. It also permits a currently regulated profession to be removed from statutory regulation when the profession no longer requires regulation for the purpose of the protection of the public. The clause also provides an updated list of the legislation that regulates professions. There is a subsection in this clause which says that this may include senior managers and leaders.

NHS Providers' view

The intention of this clause to enable broader changes to the system of regulation for healthcare professionals is welcome, as we hope it will help create a more adaptable framework of rules and processes governing the professional activities of NHS staff. We have responded positively to the government's *Regulating healthcare professionals, protecting the public* consultation which, for the

most part, sets an encouraging direction of travel towards a proportionate and flexible system of regulation which will help to ensure patient safety while better supporting the future needs of trusts as employers, and the NHS workforce as a whole.

However, we note that statutory regulation of senior managers may not resolve the issue of concern (that is, the potential for a revolving door for 'poor leaders') and is, in practice, very difficult to make effective – it will not preclude the possibility that an individual with a good track record may make a mistake, nor can it prevent non-compliant behaviour. For these reasons, we have challenged proposals to introduce regulation of senior managers. If the regulation of NHS managers is going to be pursued, we would strongly suggest that the circumstances in which the measures could be brought into statutory regulation are fully consulted upon.

Clause 124: Medical examiners

This clause amends the Coroners and Justice Act 2009 in England and allows for NHS bodies, rather than LAs, to appoint medical examiners. This means that every death in England and Wales will be scrutinised either by a coroner or by a medical examiner. It also introduces a duty on the secretary of state for health and social care to ensure that enough medical examiners are appointed in the healthcare system in England, that enough funds and resources are made available to medical examiners to enable them to carry out their functions of scrutiny to identify and deter poor practice, and to ensure that their performance is monitored by reference to any standards or levels of performance that they are expected to attain. It also introduces a power for the secretary of state to give a direction to an English NHS body in order to: require the body to appoint one or more medical examiners, set out the funds or resources that should be made available to such employed medical examiner, set out the means and methods that may be employed to monitor performance of medical examiners. These clauses do not give any English NHS body any role in relation to the way in which medical examiners exercise their professional judgment as medical practitioners.

Clause 126: Hospital food standards

This proposes to give the secretary of state powers to adopt secondary legislation that will set minimum statutory standards for food and drink provided in hospital settings.

NHS Providers' view

We support the ambition to make food in hospitals safer, healthier and more sustainable, as it is an important factor in patient recovery and wellbeing. Trusts are already working hard to ensure they meet nutritional standards and provide good quality food. Arrangements for catering within trusts vary. Some do not have the kitchen facilities to be able cater on site for patients, and so they will have

links with national wholesale suppliers. Elsewhere, some trusts have been able to develop close links with local suppliers, and others have been able to maintain their own kitchens. These differences will have an impact on how quickly, and at what cost, individual trusts will be able to comply with any new nutritional requirements. Potential cost implications could include investment in additional workforce and facilities. There would also be costs associated with renegotiating and winding down contracts and arrangements with suppliers/outsourced caterers. There must therefore be a statutory period of consultation on any new nutritional requirements before they are made to avoid unintended consequences and unrealistic asks of trusts.

Part 6: General

Clauses 130-135

Summary

This chapter of clauses includes powers which allows the secretary of state, by regulations, to make provision that is consequential on this Bill. Where regulations modify primary legislation, the affirmative procedure must be used. Otherwise, the regulations can be made under the negative procedure. This provision may be used to amend primary legislation passed in any part of the United Kingdom. Where regulations are made under this Act, those regulations may make consequential, supplementary, incidental, transitional or saving provision. Provisions also sets out the territorial extent of the Bill, further financial provision necessary as a result of the Bill, and that this part of the Bill comes into force on the day that this Act is passed and that the short title of the Bill is 'The Health and Care Act 2021'.

NHS Providers' pre-legislative work

In recent months we have been working hard to influence the legislation which has been presented today. Member engagement over the last few months, underpinned by a new member reference group for the Bill, has been extremely valuable in helping to form our positions on key issues in the run up to today's publication of the Bill.

In January, following extensive member engagement, we responded to NHSE/1's *Integrating Care: Next steps to building strong and effective integrated care systems across England* consultation, welcoming the strategic direction of travel to integrate health and care at a local level through stronger collaboration and system working, but raising concerns that many significant questions regarding ICSs and their core purpose had been left unanswered. Our full response is available on [our website](#).

In February, the government published *Integration and innovation: working together to improve health and social care for all*, setting out proposals for a Health and Care Bill. These further developed earlier proposals, as well as putting forward several new ones, as we examined in [our on the day briefing](#). Alongside the publication of the government's White Paper, NHSE/I published [five new recommendations for legislative change](#) in regard to ICSs. Our on the day briefing is also available [on our website](#).

We gave [written](#) and [oral evidence](#) to the Health and Social Care Select Committee inquiry on the White Paper, setting out priority issues for the committee to consider. We have engaged with politicians from all parties in the run up to Bill's publication and will continue to do so as the Bill progresses.

In the run up to the Bill's publication we pushed hard to secure small and focused stakeholder engagement groups with both DHSC and NHSE/I and played a key role in the discussions of these select groups in addition to ministerial meetings and regular bilateral meetings with senior decision makers across DHSC and NHSE/I.

Media statement

Bill signals way forward in fast changing health and care landscape

Responding to the publication of the Health and Care Bill, the chief executive of NHS Providers, Chris Hopson said:

"We welcome the publication of this Bill which will help provide clarity for trusts in a fast changing health and care landscape.

"Trusts have been at the forefront of the move towards closer collaboration and integration between health and care, a process that has accelerated in recent months to deal with the extraordinary pressures of the pandemic.

"The forthcoming legislation will formalise this process, so trusts and their partners can plan and cooperate more closely to help build healthier communities.

"We therefore think there is a lot to build on in the government's proposals, which herald the biggest reforms to the NHS in more than a decade.

"However we have been clear about key **areas of concern** for our members, which will need to be resolved as the Bill goes through parliament.

"It is very important to preserve the operational and clinical independence of the NHS so any new powers of direction for ministers do not impinge on issues such as procurement, treatment, drug funding and the hiring and firing of frontline NHS leaders.

"It's also important to ensure Ministers have appropriate powers in decisions over how local services are configured and that changes which improve quality and safety are not inappropriately blocked.

"There is no suggestion here that a publicly funded service like the NHS should not be held to account. Rather, that the strategic direction is the domain of politicians, who should then allow NHS leaders in operational and clinical roles - with day to day responsibility for supporting patient care - the space to deliver those strategic objectives without undue political pressure or interference.

"The new integrated care systems (ICSs) should develop to meet local needs, rather than being pushed into a one-size-fits-all approach.

"We are continuing to argue for a careful balance in how new potential controls on capital spending may be applied to foundation trusts in local systems.

"And it's vital that the legislation addresses the lack of a transparent, costed and funded long term workforce plan.

"We urge the government to continue to listen to the NHS frontline in shaping its proposals."

Guidance on the functions and governance of the integrated care board, and the model constitution

NHS England and NHS Improvement (NHSE/I) published several integrated care system (ICS) guidance documents and accompanying resources on 19 August to support systems' transition into statutory integrated care boards (ICBs) by 1 April 2022. These include:

- 1 *Interim guidance on the functions and governance of the ICB*
- 2 The model ICB constitution and supporting notes (NHSE/I [ICS implementation hub](#))
- 3 A list of statutory clinical commissioning group (CCG) functions to be conferred on ICBs (NHSE/I [ICS implementation hub](#))
- 4 *Building strong ICSs everywhere: guidance on the ICS people function*
- 5 Other guidance, including: an [HR framework](#) for developing ICBs, an ICB readiness to operate statement, and due diligence guidance (NHSE/I [ICS implementation hub](#))

This briefing summarises these resources and provides detailed commentary on the ICB functions and governance guidance, model constitution and ICS people guidance. Please contact senior policy manager Georgia Butterworth (georgia.butterworth@nhsproviders.org) if you have any comments or questions.

Summary

- The *Interim guidance on the functions and governance of the ICB* summarises the indicative mandatory governance requirements for ICBs, as set out in draft legislation and NHSE/I policy:
 - Each ICB must set out its governance and leadership arrangements in a constitution for NHSE/I approval by the end of Q4, following an engagement process.
 - The guidance confirms the minimum requirements and current expectations regarding ICB board appointments and membership. For example, ICB designate chief executives must be identified by the end of November, and other ICB board roles confirmed by the end of Q4.
 - Systems are expected to develop a “functions and decision map” alongside the constitution, showing governance arrangements are in place within the ICB and with ICS partners.
 - The ICB board will be responsible for: formulating a strategy for the organisation; holding the organisation to account for the delivery of the strategy; and shaping a healthy culture for the organisation and wider ICS partnership.

- The guidance also includes key considerations for system leaders as they design these arrangements, including for example managing conflicts of interest.
- The ICB functions and governance guidance document should be read alongside the model constitution and interim guidance on CCG functions to be conferred on ICBs:
 - The Health and Care Bill (the Bill) requires each ICB to have a constitution. NHSE/I has developed a template based on the CCG constitution to guide its development and associated consultation.
 - This model constitution covers the composition of the board, appointments process (including a nomination and selection process for partner members) and arrangements for remuneration.
 - The model constitution sets out further detail on how ICBs must ensure a balance of perspectives on the board (e.g. from all provider types) and in the ICB's decision-making process. We have been calling for this mechanism and are pleased to see it embedded here.
 - The interim guidance on CCG functions transferring to ICBs sets out the complete list of statutory CCG functions that NHSE/I expect to be conferred on ICBs in April 2022. The guidance also summarises actions that designate ICB leaders should take, with CCGs, to prepare to discharge their statutory functions as ICBs.
- The ICS people function guidance builds on the priorities set out in the People Plan and aims to support ICBs and their partners to deliver outcome-based people functions from April 2022.
- The HR framework provides practical support for CCGs as they transition to statutory ICBs. NHSE/I states that the ICS readiness to operate statement and checklist will support system leaders to assess progress and transition towards the establishment of ICBs. The due diligence guidance outlines legal processes in relation to the establishment of ICBs and the abolition of CCGs.

1. Summary of the guidance on ICB functions and governance

This interim guidance builds on the ICB governance arrangements outlined in the Bill and *ICS design framework*. The statutory instruments and guidance enabling the ICB and integrated care partnership (ICP) cannot be made formally until the Bill is enacted, which is expected in April 2022, so this interim guidance aims to support system partners to make the necessary preparations. It confirms the 'must do' requirements (subject to legislation) and sets out key considerations to inform local discussions on the design and implementation of ICBs and ICPs (see Annex 1).

NHSE/I expects system leaders to use the guidance and accompanying resources to inform aspects of their transition to statutory organisations in April 2022, including:

- The development of the ICB constitution, following engagement with relevant partners and confirmation that ICB designate board members are supportive of its terms, with a final version being approved by NHSE/I by the end of Q4.
- ICB board recruitment, with designate chief executives identified by November; a designate finance director, medical director, director of nursing and other executive roles in the ICB identified before the end of Q4; and designate partner members and any other designate ICB senior roles identified by the end of Q4.
- Commissioning functions organised across the ICS footprint, with decisions on arrangements at system and place level being finalised by the end of Q3.
- Functions and decision map showing arrangements within the ICB and with ICS partners, with a final version due before the end of Q4.

NHSE/I expect the core components of the ICB governance arrangements to include:

- A statutory committee called the ICP, with the expectation that each ICB will need to align its constitution and governance with the ICP. The guidance highlights the key role of ICPs, as set out in the *ICS design framework*, and refers to new ICP guidance that will be issued by the Department of Health and Social Care, in partnership with NHSE/I and the Local Government Association.
- A statutory body called the ICB, with the expectation that each ICB will need to put arrangements in place to ensure they can effectively discharge their full range of duties and functions. The guidance references the 12 key functions of the ICB as outlined in the *ICS design framework*.
- Place-based partnerships, with the expectation that ICBs will be able to arrange for decisions to be made by/with place-based partnerships, with the ICB remaining accountable for NHS resources at place-level. Each ICB should therefore set out the role of place-based leaders within its governance arrangements.
- Provider collaboratives, with the expectation that provider collaboratives agree specific objectives with one or more ICB, as highlighted in NHSE/I's recent [guidance](#) (August 2021).

NHSE/I notes that this is not an exhaustive list and states that systems will want to consider a much wider range of governance vehicles to conduct their business.

ICB commissioning functions

From April 2022, the statutory functions that currently sit with CCGs will be conferred on ICBs, along with staff, assets and liabilities (including commissioning responsibilities and contracts). Relevant CCG duties will be transferred, including those regarding health inequalities, quality, safeguarding, children

in care and children and young people with special educational needs or disability. The full expected list of CCG functions to be conferred has been published (see summary in section 3 below).

NHSE/I reiterates the intention to delegate some direct commissioning functions to ICBs as soon as operationally feasible from April 2022. NHSE/I wrote to trusts in July setting out these changes. Statutory ICBs will also have the flexibility to deliver commissioning activities differently e.g. with providers/local authorities, subject to legislation.

Decision-making within an ICB

With regards to decision making, NHSE/I expects ICBs to publish a scheme of reservation and delegation which sets out:

1. Functions that are reserved to the board
2. Functions that have been delegated to an individual or committees/sub committees
3. Functions delegated to another body or to be exercised jointly with another body

ICBs must also develop a functions and decision map that:

- Is locally defined
- Sets out where decisions are taken
- Outlines the roles of different committees/partnerships
- Is easily understood by the public

Board of the ICB, including membership, remuneration and committees

The guidance provides a list of the minimum membership of the unitary board of the ICB, which reflects the list in the *ICS design framework*. It also outlines the unitary board's key responsibilities as:

- Formulating a strategy for the organisation
- Holding the organisation to account for the delivery of the strategy
- Shaping a healthy culture for the organisation and the wider ICS partnership

The guidance makes clear that ICB executives will be employed or seconded to the ICB and will be paid as employees. Independent chairs and non-executive members will be remunerated for their time (in line with forthcoming NHSE/I guidance). The legislation will also allow for the 'partner' members to be remunerated where relevant. The board will decide remuneration for board members not employed by the ICB, but all bodies should ensure no members are paid twice for the same time by different organisations.

The guidance outlines the ways in which ICBs must demonstrate how they are driving equality, diversity and inclusion (EDI), ensuring for example that: the workforce represents the diversity of the NHS; the culture promotes inclusion and embraces diversity; and employees and board members display inclusive behaviour.

The guidance outlines the fact that the legislation is expected to require all ICBs to establish an audit committee and a remuneration committee, as well as giving ICBs the power to appoint individuals who are not board members or ICB staff to be committee members and to delegate its functions to be exercised by or jointly with partners e.g. trusts, local authorities, other ICBs, or NHSE/I.

ICBs will have statutory duties regarding the management of conflicts of interest, including maintaining one or more registers for board members, committee members and employees. The guiding principle for any conflict of interest policy is to ensure that decisions are made in the public interest by avoiding any undue influence. ICB boards are encouraged to set aside the necessary time to debate and explore these issues as part of their developmental journey.

NHS Providers view

This interim guidance document on ICB functions and governance begins to build on the requirements set out in the *ICS design framework* (June 2021) and the Health and Care Bill (as introduced in July 2021). It provides some further clarity on the role and responsibilities of the ICB, while leaving scope for the ICB and its constituent organisations to determine local governance infrastructures. We support NHSE/I's intention to maintain a permissive framework for systems and will engage with trust leaders to assess whether this guidance enables sufficient local flexibility for systems to continue designing what works best for their local populations, services and circumstances. As the new ICS model evolves, the guidance will also need to be adaptable in the context of any issues that may arise.

Trust leaders and their local partners are already involved in many different forms of collaboration, which all aim to improve services and patient care, and deliver efficient use of resources, in a similar vein to the new Triple Aim policy which will be implemented through the Bill. Trusts and their partners are already designing, delivering and overseeing collaborative strategies, and managing risk effectively, in the absence of the ICB structure. Systems and NHSE/I national and regional teams must continue to acknowledge this reality and work with it, rather than create a whole separate ICB governance infrastructure. Building on what works in existing ICS governance, and keeping focused on the purpose and aims, will be crucial to the success of system working.

We have engaged extensively with NHSE/I in the design of ICBs, including emphasising the importance of the full range of provider types having sufficient access and input to the ICB decision-making process. While we welcome the requirement in the model constitution on ICBs to establish a mechanism which enables the views of trusts to feed into ICB decisions, this ICB governance guidance only states that the constitution must confirm that ICB board members are supportive of its terms; it does not explicitly require the ICB to ensure all trusts and wider partners are involved in the development of the constitution and/or supportive of its terms, nor provide recourse to a challenge function in extremis. If the ICB is not established by its constituent organisations, it risks setting up a divisive culture in the system. This risk is exacerbated by the articulation of ICBs as separate bodies to their constituent organisations, rather than being a sum of their parts. The ICB needs to be accountable to its local populations and constituent organisations to realise its ambitions.

We support the principles of subsidiarity, minimal bureaucracy and clear accountabilities as set out in Annex 1 to inform the design and development of local system governance arrangements. We also support the focus on ICBs demonstrating how they are driving EDI throughout the system, and the emphasis on the ICP challenging all partners to demonstrate progress in reducing inequalities and improving outcomes. NHSE/I regional teams will need to support systems to develop clear decision-making arrangements and accountabilities. The guidance refers to ICB boards not only formulating the strategy for the organisation but also holding the organisation to account for the delivery of the strategy. It also states that provider collaboratives will agree specific objectives with one or more ICB, and agree how to achieve those objectives, but the ICB will be accountable. These complex arrangements will be challenging for trusts and their partners to navigate and avoid overlapping, unclear accountabilities.

Another challenge for ICBs and their constituent organisations will be how to manage conflicts of interest. While trusts and their partners already navigate these challenges, the new provider selection regime and collaborative approach to decision-making will make contracting and commissioning decisions more complex. We look forward to continuing to work with NHSE/I and partners to explore these outstanding questions and concerns in more detail.

2. Model constitution and supporting notes

NHSE/I has developed a model constitution – based on the current CCG constitution – for system leaders and CCGs to guide the development of, and consultation on, their ICB constitution. The

model constitution is based on the proposed requirements as set out in the Bill. The constitution will need to be updated in line with any changes to the legislation and NHSE/I policy.

The ICB can apply to the newly merged NHSE to vary the constitution (NHSE/I will publish an application procedure), or NHSE can vary the constitution under its own initiative. The constitution should set out a local procedure for who may propose a change to the constitution and how this is done, who will be consulted on any proposed changes, and how the decision about proposed changes will be taken prior to an application being made to NHSE (typically this will be the ICB board).

The supporting notes accompanying the model constitution suggest content beyond the legal requirements (as currently drafted) of what needs to be included in the ICB constitution, for example:

- Explaining how the ICB differs from CCGs, and drawing out mutual accountability arrangements;
- Referring to how this constitution aligns with the ICP's terms of reference; and
- Clarifying that ICBs may decide to have more than one 'ordinary member' from each sector, and more than two independent non-executive members, beyond the statutory minimum and NHSE/I policy requirements.

Composition of the board of the ICB

The constitution of the ICB must set out board roles and membership and ensure a balance of perspectives on the board. For example, the ICB must ensure that the perspectives of all sectors and types of provider within the ICB's area are included (e.g. acute, mental health, community and specialist). ICBs will need to ensure that the views of patients, carers and the public are heard and included in the board decision-making process, along with clinical and professional groups. Beyond the composition of the board itself, ICBs should ensure there are mechanisms for including the full range of perspectives through its decision-making model and structures. ICBs will also be expected to comply with good governance practices, including on board size, to allow appropriate decision-making to take place. The constitution recommends limiting the number of participants as most parties will play their largest role in the partnership or in operational fora and task and finish groups.

Appointments process for the board

The constitution of the ICB must set out board roles, the process of appointing partner members and eligibility criteria that must be fulfilled. Each member of the ICB must:

- By law be subject to the chair's approval (excluding the chief executive who is approved by NHSE/I)
- Comply with the criteria of the fit and proper person test
- Be willing to uphold the Nolan Principles
- Fulfil the requirements in the role specification
- Meet the eligibility criteria set out in the constitution (some nationally and some locally defined)

The constitution will also set out the appointments process for ICB board members, including the terms and number of terms permitted. NHSE/I will publish a process to describe how chairs and chief executives will be appointed, and how appointments proposed by ICBs will be approved.

The Bill states that the partner members are to be 'nominated jointly' by their respective sector. The constitution must set out the appointment process of partner members, including who may take part (regulations will set out which organisations can take part in any nomination process), what the procedure entails and what the decision-making arrangement is. The process should reflect NHSE/I guidance. As a minimum, it must include two parts:

- 1 An element that is designed to build the confidence of stakeholders that the perspective of the individual will contribute to the board discussions (the nomination process).
- 2 An element that is designed to assess that the individual can demonstrate they have the skills, knowledge, experience and attributes required to fulfil the role (the selection process).

The partner member from the trust sector will need to be an executive director of a trust within the ICB's area. The *ICS design framework* states this will often be the chief executive.

While the ICB board should normally include medical/nursing/finance director roles, NHSE/I recognises they may be fulfilled in different ways, such as by different job titles or holding other responsibilities with a wider portfolio. They may be an employee of another organisation as well as the ICB. The medical director must be a registered medical practitioner, but the director of nursing does not have to be a registered nurse or midwife.

ICBs may choose to appoint more than the minimum requirement of two independent members. It is good practice for one independent member to be appointed as a senior independent member. The ICB may want to add other local criteria, such as requiring non-executive members to have a connection to the ICB area. The ICB should consider whether individuals who have served in

equivalent roles on the boards of previous and current NHS bodies locally could be sufficiently independent. The chair's terms of appointment will be determined by NHSE/I.

Arrangements for remuneration will be agreed by the remuneration committee in line with the ICB's policy and any NHSE/I guidance. Remuneration for chairs, non-executives and chief executives will be set by NHSE/I. The duties of the remuneration committee will be locally determined, such as setting the ICB pay policy and setting remuneration for board members.

Generally, it is expected that decisions of the ICB will be reached by consensus. Should this not be possible then a vote will be required, and the constitution will set out the process for voting (which should be considered a last resort).

Arrangements for the exercise of ICB functions

The ICB may grant authority to any of its members/employees or a committee/sub-committee to act on its behalf. The ICB may also arrange for functions to be exercised by a joint committee or enter partnership arrangements with a local authority under which the local authority exercises specified ICB functions or the ICB exercises specified local authority functions, or the ICB and local authority establish a pooled fund. The ICB remains accountable for all its functions, including those it has delegated, so the constitution should describe local arrangements for assurance. ICB committees may include or be formed from individuals who are neither employees of nor board members of the ICB.

Arrangements for conflict of interest, accountability and transparency

The ICB will be required to manage actual and potential conflicts of interest to ensure the integrity of the ICB's decision-making processes. For example, where independent providers hold contracts for services, NHSE/I sees it would be appropriate for the ICB to involve them in decisions, such as about pathway design at place level, but this would be distinct from contracting and commissioning considerations. NHSE/I may issue guidance for ICBs in due course, but ICBs should follow [NHS-wide guidance](#) for now. ICBs may choose to appoint a conflicts of interest guardian.

The ICB will demonstrate its accountability to local people, stakeholders and NHSE/I. Board and committee meetings will be held in public, with papers and minutes published. The ICB will comply with the requirements of the NHS provider selection regime and ensure there are appropriate governance structures that will deal with any challenges following decisions. ICBs will need to publish their intentions for arranging services in advance, publishing contracts awarded and keeping records of decision-making.

NHS Providers view

We welcome the publication of the model constitution for ICBs as a helpful means of supporting systems to prepare for their transition to statutory bodies in April 2022. Creating template documents that can be adapted locally is helpful for systems and their constituent organisations to avoid reinventing the wheel. The Bill includes a lot of detail as to what must be in the ICB constitution, so while we support NHSE/I's intention to enable maximum local flexibility, we are conscious there is little latitude for NHSE/I to streamline the statutory requirements. We will continue to engage with trust leaders on how emerging frameworks and guidance documents are carrying through the ambition of local flexibility to implementation.

We welcomed the opportunity to feed into the development of the model constitution and are pleased to see that much of our feedback has been incorporated in this final draft. In line with our feedback, the model constitution provides some helpful precision about the nature of the unitary board and clarity about the ICB's powers, including making delegations and being accountable for all delegated decision-making. It also clarifies the role of the ICB board and senior independent member. We look forward to continuing to work closely with NHSE/I to develop a clear policy framework for ICBs and their constituent organisations.

Constitutions should be used by boards as tools to assist them in the governance of their organisations and should also act to assure stakeholders that appropriate governance infrastructures are in place. Constitutions need to be adaptable to local conditions and changing circumstances, as well as able to change provisions that do not work well in practice. The Bill includes a provision that constitutional changes submitted by ICBs will not take effect until approved by the newly merged NHSE. It is important therefore that NHSE is able to approve proposed constitutional changes promptly through a simple process and should confine its role to ensuring that any proposed changes are lawful.

One of our priority concerns on behalf of trust leaders is the importance of ICB boards taking account of the views of key stakeholders, particularly constituent organisations within the ICB area, in making decisions. We therefore welcome the emphasis in the supporting notes on ensuring a balance of perspectives on the board of the ICB, including all sectors and types of providers. We have also called for a mechanism to include this full range of perspectives through the ICB decision-making structures and welcome this requirement in the supporting notes. These arrangements will be crucial to

sustaining the ICS as a sum of its parts, and we urge NHSE/I to apply this consultative focus consistently, including in the establishment of the first constitution and any subsequent amendments.

The role of non-executive board members will be crucial on the ICB, facilitating strong challenge and assurance at board level. Trust leaders have stressed the need for non-executives to form a majority on the board, and we will continue to call for this to be adopted as best practice. While the model constitution emphasises consensus decision-making, it is important for ICBs to welcome effective challenge and well-reasoned dissent. Trust leaders will also want to consider how their organisation's non-executives could be linked into the new ICB governance infrastructure.

We remain concerned about the ICB chair being appointed (and possibly removed) by NHSE/I with approval from the Secretary of State for Health and Social Care, and no involvement of the ICB members or wider system partners. This is concerning as the chair needs to have the confidence of the ICB and system partners. We urge NHSE/I to ensure a significant role for these bodies in the recruitment of the chair, even if powers of appointment lie elsewhere, and include a description of the chair's independence in the handbook referenced in the supporting notes.

3. List of statutory CCG functions to be conferred on ICBs

This document forms part of the ICB functions and governance guidance. It sets out a list of current CCG statutory functions that will be conferred on ICBs, subject to the Health and Care Bill being passed. NHSE/I expects most CCG statutory functions to be conferred on ICBs in April 2022, along with the transfer of all CCG assets and liabilities. Some functions and duties may be amended or strengthened.

The guidance also summarises actions that designate ICB leaders should take, with CCGs, to prepare to discharge their statutory functions as ICBs. NHSE/I expects ICS/ICB leaders to work with CCGs through the list of statutory functions in the document to ensure responsibility for each function is clear within their proposed new ICB arrangements and that the ICB will have the capacity to carry them out effectively. This includes deciding what statutory functions should be delivered at ICS or place level – this will be for local determination. The Bill also makes provision for ICBs to delegate certain functions to trusts, but ICBs will still be held to account for the discharge of these functions. There will be some functions that ICBs will not be able to delegate to providers e.g. managing conflicts of interest.

4. Building strong ICSs everywhere: guidance on the ICS people function

The [ICS people function guidance](#) builds on the themes and priorities set out in the NHS people plan, [published in July 2020](#), helping to set a framework for the consideration and undertaking of workforce activity at system level. The document clarifies how partners within an ICS are expected to contribute to this, but does not seek to describe “the full breadth of ICS workforce arrangements”. It sets out priorities for the remainder of this financial year, points towards requirements for greater collaboration over resource decisions at system level from April 2022 (which will require further guidance) and provides a relatively detailed steer on the type of responsibilities trusts and other partners may consider for delivery at system level.

The document makes it clear that NHSE/I “does not prescribe a ‘one size fits all’ approach to establishing, developing and delivering the ICS people function”. On the contrary, this guidance has been produced with an intention to “support local flexibility”, recognising that systems will have different approaches and existing levels of collaboration on workforce activity, and that each ICS will need to proceed in a manner chosen “according to their particular circumstances”.

Priorities for action: 2021/22

While some systems will be more ‘advanced’ towards undertaking a greater level of workforce activity at ICS level, the guidance prescribes a small but significant list of immediate ‘preparatory’ actions for system leaders and partners within the ICS as part of establishing the people function. They are asked to:

- 1 Agree the formal ICB and ICP governance and accountability arrangements for people and workforce in the ICS, including appointed SROs;
- 2 Agree how and where specific people functions are delivered within the ICS (for example, ICB, provider collaborative, place-based partnership);
- 3 Review, refresh or establish (where not in place) the ICS People Board in line with wider ICS governance and accountabilities, with clear reporting arrangements into the ICS Board; and
- 4 Assess the ICS’s readiness, capacity and capability to deliver the people function, by identifying gaps and developing the necessary infrastructure to address these.

NHSE/I encourages system leaders and partners to utilise its [System Development Progression Tool](#), among other resources, to support this process.

Principles and ambitions of the people function: from April 2022

Within the guidance, NHSE/I had created “10 outcomes-based functions”, which could be described as overarching principles and ambitions for the workforce within each ICB. These ten broad workforce priority areas will form the basis on which system leaders and partners seek to make their areas better places to work for staff:

- 1 Supporting the health and wellbeing of all staff
- 2 Growing the workforce for the future and enabling adequate workforce supply
- 3 Supporting inclusion and belonging for all, and creating a great experience for staff
- 4 Valuing and supporting leadership at all levels, and lifelong learning
- 5 Leading workforce transformation and new ways of working
- 6 Educating, training and developing people, and managing talent
- 7 Driving and supporting broader social and economic development
- 8 Transforming people services and supporting the people profession
- 9 Leading coordinated workforce planning using analysis and intelligence
- 10 Supporting system design and development

These ‘functions’ align very closely with the priorities of the people plan and the document provides a chart of intended outcomes, overarching ICB responsibilities within the functions, and a set of potential (non-mandatory) workforce activities that could be delivered at system level to meet the stated ambitions.

From April 2022, ICBs will be expected to coordinate and allocate the resources required to enable delivery of the people function, with buy in from all constituent partners within the system and with support from national and regional teams.

“One workforce” and principles of subsidiarity

The guidance contains a strong focus on a “one workforce” approach within ICBs, urging system leaders to consider where activity at scale can have the greatest impact for local communities. It emphasises that the ICB will hold responsibility for clinical and non-clinical staff working in primary and community care (alongside secondary and tertiary care), and that ICBs will be expected to support and collaborate with those who provide wider community services, including in local government, other public services and in the voluntary sector.

However, the document makes clear that the principles of subsidiarity will be applied to staff support and workforce management, noting the many advantages (and necessities) of workforce activity

carried out 'below' system level, whether by provider organisations, primary care networks, at place, or through provider collaboratives.

The guidance states that individual organisations within a system will continue to have direct responsibility for the staff in their own organisations. Further clarification is provided on the type of activity carried out at regional level and by national NHS bodies as well, with an emphasis on the continued responsibility of the seven regional people boards to support the identification and delivery of at scale work within and across ICBs.

NHS Providers view

The ICS people function guidance will provide a useful reference point for trusts as many seek to work more closely with system partners on workforce issues, and indeed on the delivery of key workforce activity across wider footprint areas. During the development of this guidance (and the HR framework discussed below), trust leaders have sought clarification on the question of 'who will do what' when it comes to staffing issues, particularly given the steer from NHSE/I to set up ICBs as the primary forum for workforce planning in the NHS. This aim for workforce planning is yet to happen in many places, so – while the maturation of regional people boards have certainly aided progress – trust leaders will be pleased to see the guidance contains a clear message around individual organisations retaining responsibility for their employed staff, and will largely support the absence of a 'one size fits all' approach to delivery of workforce activity at system level.

We welcome the focus on developing infrastructure for the ICS people function in the short-term and support the emphasis on building effective governance structures while assessing readiness for system-level delivery. While the guidance helps to provide a framework for realising the benefits of workforce activity at scale, it is crucial not to lose sight of the ever-present barriers to achieving this, not least the very large and persistent workforce gaps facing the service, which can limit the ability of staff to work more flexibly across organisational boundaries. Current operational pressures will also constrain trust leaders and people professionals in their efforts to speedily put new, legally binding policies in place and form effective collaborations with system partners to implement them.

5. Other guidance documents for ICBs

HR framework for developing ICBs

NHSE/I has developed an HR framework to support CCGs and ICSs as they develop and transition towards the new statutory ICBs. It reiterates NHSE/I's ambitions to provide employment stability and

ensure a safe and effective transfer of staff, as well as giving guidance on how to manage the transition. All staff below board level will 'lift and shift' from one organisation to the other, to minimise disruption. All board-level staff will not be covered by the employment commitment and will be affected by the need to establish designate executive ICB roles. There is some flexibility built into the framework around which roles are considered board level.

ICB readiness to operate statement and checklist

This guidance is intended to support existing ICS leaders, and designate ICB leaders as they are appointed, to prepare for the legal and operational establishment of ICBs and abolition of CCGs on 1 April 2022. It includes a template ICB readiness to operate statement (ROS) and accompanying checklist. It describes how the checklist will be used to support preparations for, and assess progress towards, the establishment of ICBs. Key actions from the guidance include:

- The requirement for each designate ICB CEO and their relevant regional director to co-sign the ROS in March 2022. The ROS is a high-level statement to confirm that all critical elements are in place ready for the establishment of the ICB on 1 April 2022 and arrangements are in place for the ICB to fulfil its role within the wider ICS.
- Reporting on progress against the ROS checklist at the end of Q2 and Q3 2021/22 and in mid-February 2022. The checklist reflects core elements in the *ICS design framework* as well as the due diligence activities needed to prepare for the duties of CCGs to be transferred to ICBs.

Due diligence, transfer of people and property from CCGs to ICBs, and CCG close down

This guidance is to support CCGs and ICSs to transition effectively to ICBs. The guidance sets out the definition of due diligence and the planning processes involved in ensuring an effective transfer of CCG duties. It also covers information on the legal documentation and process for abolishing CCGs and closing down activities. The key actions from the guidance include:

- CCG accountable officers ensuring that their teams plan for and undertake robust and proportionate due diligence, making use of the due diligence checklist (on the [NHSE/I ICS implementation hub](#)).
- In March 2022, CCG accountable officers should provide written assurance of due diligence to the relevant NHSE/I regional directors and (if appropriate) the designate ICB chief executive.



NHS oversight metrics for 2021/22

June 2021

Oversight theme	NHS Long Term Plan/People Plan headline area	2021/22 Planning guidance deliverable	Measure name (metric)	CCG	Trust	ICS
Quality, access and outcomes	Primary and community services including new community services response times	All general practices to be delivering at, or above, pre-pandemic appointment levels, including through consolidating and maximising the use of digital consultation methods and technology	Access to general practice – number of available appointments	✓		✓
			Proportion of the population with access to online GP consultations	✓		✓
		Maximising dental activity and targeting capacity to minimise deterioration in oral health and reduce health inequalities	Dental activity	✓		✓
		Transforming community services and improving discharge	2-hour urgent response activity	✓	✓	✓
			Discharges by 5pm	✓	✓	✓
			Delayed transfers of care per 100,000 population	✓		✓
		Restoration of elective and cancer services*	Maximise elective activity, taking full advantage of the opportunities to transform the delivery of services	Elective activity levels	✓	✓
	Overall size of the waiting list			✓	✓	✓
	Patients waiting more than 52 weeks to start consultant-led treatment			✓	✓	✓
	Restore full operation of all cancer services		Cancer referral treatment levels	✓	✓	✓
			People waiting longer than 62 days	✓	✓	✓
			% meeting faster diagnosis standard	✓	✓	✓

Oversight theme	NHS Long Term Plan/People Plan headline area	2021/22 Planning guidance deliverable	Measure name (metric)	CCG	Trust	ICS
		Maximise diagnostic activity focused on patients of highest clinical priority	Diagnostic activity levels	✓	✓	✓
	Improve cancer outcomes: early diagnosis and survival		Proportion of people who survive cancer for at least 1 year after diagnosis	✓		✓
			Proportion of cancers diagnosed at stages 1 or 2	✓		✓
	Outpatient reform: avoidance of up to a third of outpatient appointments	Embed outpatient transformation	Advice and guidance and patient initiated follow-up activity levels	✓	✓	✓
	Implementation of agreed waiting times		% of all outpatient activity delivered remotely via telephone or video consultation	✓	✓	✓
			UEC performance measure*	✓	✓	✓
			30-minute ambulance breaches	✓	✓	✓
			Ambulance response times		✓	
	Maternal and children's health**	Continue delivery of the maternity transformation measures set out in the NHS Long Term Plan	% women on continuity of care pathway		✓	
			Number of stillbirths per 1,000 total births			✓

Oversight theme	NHS Long Term Plan/People Plan headline area	2021/22 Planning guidance deliverable	Measure name (metric)	CCG	Trust	ICS
		Implement the five elements of the Saving Babies' Lives care bundle	Number of neonatal deaths per 1,000 live births			✓
	Emergency care: on agreed trajectory for same day emergency care (SDEC) and integrated urgent care services (IUC)	Maximise the use of booked time slots in A&E	% of patients referred to an emergency department by NHS 111 that receive a booked time slot to attend	✓		✓
		Increase % of patients seen and treated on the same day or within 12 hours if this spans to midnight	% of zero-day length of stay admissions (as a proportion of total)		✓	✓
		Reduce avoidable A&E attendances by directing patients to more appropriate urgent care settings	% of unheralded patients attending EDs	✓		✓
		Meet the MHIS and use the investment to grow the workforce and deliver transformation of care	Delivery of the mental health investment standard	✓		✓
	Mental health	Deliver the mental health ambitions outlined in the NHS Long Term Plan, expanding and transforming core mental health services	NHS Long Term Plan metrics for mental health	✓	✓	✓
		Learning disability and autism: reducing	Continue to reduce reliance on inpatient care (adults and children)			✓
			Reliance on specialist inpatient care for adults/children with a learning disability and/or autism			✓

Oversight theme	NHS Long Term Plan/People Plan headline area	2021/22 Planning guidance deliverable	Measure name (metric)	CCG	Trust	ICS
	inpatient rate and increasing learning disability physical health checks	Make progress on the delivery of annual health checks for people with a learning disability	Number of people with a learning disability on the GP register receiving an annual health check	✓		✓
	People will get more control over their own health by rolling out NHS personalised care model across the country	Systems should continue and, where possible, accelerate the delivery of existing requirements, including personalised health budgets, wheelchairs for children, social prescribing referrals and personalised care and support plans	Number of personalised care interventions	✓		✓
Personal health budgets			✓		✓	
Social prescribing unique patient referrals			✓		✓	
Delivering safe, high quality care overall			Summary hospital-level mortality indicator		✓	
			Overall CQC rating (provision of high-quality care)		✓	
			Acting to improve safety (safety culture theme in NHS Staff survey)		✓	
			Patient experience of GP services	✓		✓
			Potential under-reporting of patient safety incidents		✓	
			National Patient Safety Alerts not completed by deadline		✓	

Oversight theme	NHS Long Term Plan/People Plan headline area	2021/22 Planning guidance deliverable	Measure name (metric)	CCG	Trust	ICS
			Methicillin-resistant <i>Staphylococcus aureus</i> (MRSA) bacteraemia infection rate		✓	
			<i>Clostridium difficile</i> infection rate		✓	
			<i>E. coli</i> bloodstream infections	✓	✓	✓
			Venous thromboembolism (VTE) risk assessment		✓	
			Antimicrobial resistance: appropriate prescribing of antibiotics and broad-spectrum antibiotics in primary care	✓		✓
Preventing ill health and reducing inequalities	Screening and vaccination programmes meet base levels in the public health agreement or national goals	First COVID-19 vaccination dose offered to all adults by the end of July	% of adults vaccinated			✓
		Maximise efforts to recover immunisation services that were paused or had reduced uptake due to the COVID-19 pandemic	Population vaccination coverage – MMR for two doses (5 year olds) to reach the optimal standard nationally (95%)	✓		✓
		Flu vaccination	Number of people receiving flu vaccination	✓	✓	✓
		Restore of NHS bowel cancer screening programme	Bowel screening coverage, aged 60–74, screened in last 30 months	✓		✓
		Restore the national breast screening service back to the key performance indicator threshold	Breast screening coverage, females aged 50–70, screened in last 36 months	✓		✓

Oversight theme	NHS Long Term Plan/People Plan headline area	2021/22 Planning guidance deliverable	Measure name (metric)	CCG	Trust	ICS	
		Restore cervical screening	Cervical screening coverage, females aged 25-64, attending screening within target period	✓		✓	
		Improvements for people with conditions such as diabetes, CVD and obesity	Improved uptake of the NHS diabetes prevention programme	Number of people supported through the NHS Diabetes Prevention programme	✓		✓
	Diabetes patients that have achieved all the NICE-recommended treatment targets (adults and children)			✓		✓	
	Make progress against the NHS Long Term Plan high impact actions to support stroke, cardiac and respiratory care		Number of people with CVD treated for cardiac high risk conditions	✓		✓	
			Number of people receiving mechanical thrombectomy	✓		✓	
	Increase referrals to NHS digital weight management services		Number of referrals to NHS digital weight management services	✓		✓	
	Reducing inequalities	Restoring NHS services inclusively	Ethnicity and most deprived quintile proportions across service restoration and NHS Long Term Plan metrics	✓	✓	✓	
		Accelerating preventative programmes	COVID-19 vaccination uptake for black and minority ethnic groups and the most deprived quintile compared to the national average			✓	
		Ensuring datasets are complete and timely	Proportions of patient activities with an ethnicity code	✓	✓	✓	
		Leadership		Quality of leadership†	✓	✓	✓

Oversight theme	NHS Long Term Plan/People Plan headline area	2021/22 Planning guidance deliverable	Measure name (metric)	CCG	Trust	ICS
Leadership and capability			Aggregate score for NHS Staff Survey questions that measure perception of leadership culture ^{††}	✓	✓	✓
People	People Promise	Supporting the health and wellbeing of staff and taking action on recruitment and retention	People promise index ^{††}	✓	✓	✓
	Looking after our people		Health and wellbeing index ^{††}	✓	✓	✓
			Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from (a) managers, (b) other colleagues, (c) patients/ service users, their relatives or other members of the public in the last 12 months	✓	✓	✓
			Proportion of people who report that in the last three months they have come to work despite not feeling well enough to perform their duties	✓	✓	✓
			Percentage of staff who say they are satisfied or very satisfied with the opportunities for flexible working patterns	✓	✓	✓
			% of jobs advertised as flexible	✓	✓	✓
			Staff retention rate (all staff)	✓	✓	✓

Oversight theme	NHS Long Term Plan/People Plan headline area	2021/22 Planning guidance deliverable	Measure name (metric)	CCG	Trust	ICS
			Sickness absence (working days lost to sickness)	✓	✓	✓
			Proportion of staff who say they have a positive experience of engagement	✓	✓	✓
			Number of people working in the NHS who have had a 'flu vaccination	✓	✓	✓
	Belonging in the NHS		Proportion of staff in senior leadership roles who are (a) from a BME background, (b) women	✓	✓	✓
			Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age	✓	✓	✓
	Growing for the future		Number of registered nurses employed by the NHS (WTE)			✓
			Number of doctors working in general practice (WTE)	✓		✓
			Additional primary care WTE through ARRS	✓		✓
			Number of healthcare support workers employed by the NHS			✓
			Mental health workforce growth	✓		✓

Oversight theme	NHS Long Term Plan/People Plan headline area	2021/22 Planning guidance deliverable	Measure name (metric)	CCG	Trust	ICS
Finance and use of resources	The NHS will return to financial balance: NHS in overall financial balance each year	Systems to manage within financial envelopes	Performance against financial plan	✓	✓	✓
			Underlying financial position	✓	✓	✓
			Run rate expenditure	✓	✓	✓
			Overall trend in reported financial position	✓	✓	✓

Note: This list may be updated in year to reflect planning guidance for the second half of the year.

* A response to the consultation to the UEC clinically-led review of standards will be published in due course.

** We will also monitor delivery against the other priorities set out in the planning guidance, including progress against implementing the immediate and essential actions from the Ockenden report.

† Based on CQC leadership rating for trusts and GP practices, and NHS England and NHS Improvement assessment for CCGs and ICSs.

†† Metric under development.

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