Written evidence submitted by NHS Providers (HSC0003)

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS trusts and foundation trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate. NHS Providers has all trusts in voluntary membership, collectively accounting for £92bn of annual expenditure and employing more than one million staff.

Key points

- The proposals set out in the Department of Health and Social Care's (DHSC) white paper provide an important opportunity to accelerate the move to integrate health and care at a local level, replace competition with collaboration and reform an unnecessarily rigid NHS approach to procurement.
- While we understand the motivation to put forward an extensive set of legislative proposals, we acknowledge that this will be a wide-ranging bill, including a number of provisions not previously considered by the sector.
- These proposals come at an extremely challenging time for the NHS and we would welcome discussion about how quickly legislative change can be implemented, given the immediate operational pressures the NHS is facing, and will continue to face throughout 21/22 as trust leaders and their partners seek to stabilise the service and recover the care backlog.
- The white paper introduces a distinction between an ICS NHS body and an ICS health and care partnership – while we welcome the focus the broader partnership could bring in addressing health inequalities, it is not yet clear how the two will work together in practice and to what extent this will reduce bureaucracy.
- We do not believe that the proposals for a reserve power to set a legally binding capital limit (CDEL) on individual named foundation trusts address the root of the problem of insufficient capital investment available within the system. We will be seeking a number of safeguards not currently explicit in the white paper to ensure this proposal operates transparently, as a reserve power.
- The white paper also sets out a number of proposals which cumulatively amount to far-reaching powers for the secretary of state. This includes greater powers of direction over NHS England, the potential for the secretary of state to create new integrated care trusts, and the potential for the secretary of state to intervene at an earlier stage in local service reconfigurations. We are actively engaged in discussions with the DHSC to understand the intent and practical application of these proposed powers.
- We look forward to working closely with the government, wider stakeholders and trust leaders, to get the detail of these proposals right and ensure they contribute to improvements in care for patients and service users as intended.

Overview

1. We welcome the DHSC's ambition to create a flexible, permissive legislative framework that aims to remove barriers to collaboration and enable more joined-up care. Trusts have been working with system partners for several years in sustainability and transformation partnerships (STPs) and latterly integrated care systems (ICSs) to improve population health and achieve best use of resources. The proposals rightly aim to build on this strategic direction of travel and offer the flexibility to build on local progress.

2. The significance of any move to amend the legislative framework within which the NHS operates should not be underestimated. The proposals in *Integration and innovation: working together to improve health and social care for all* to strengthen system working build on developments already underway but still amount to a significant structural and cultural shift in ways of working within the health and care sector.

3. It will be important for government and NHS England and NHS Improvement (NHSE/I) to bear in mind the sustained operational pressures facing the health and care sector when considering the implementation timetable for any legislative change of this scale. Trusts and their staff are prioritising their response to high levels of COVID-19 hospitalisations and the need maintain non-COVID care and recover a known and unknown care backlog in some services. Demand for mental health services, and for community services has increased significantly. Trusts are also playing a pivotal role, alongside primary care colleagues, in delivering the vaccination programme, which will remain a significant undertaking over the next six months at least, and perhaps become a cyclical requirement. Frontline staff are exhausted and will need time to recover psychologically and physically and take delayed annual leave.

   The scope, scale and pace of these changes mean it is more important than ever to engage trusts and their system partners in the policy development and Bill drafting process but the unprecedented pressures facing the service mean NHS leaders will have limited capacity to give that engagement process their full attention. We must also reflect on the appropriateness of changing the structure of the NHS at a time when it is operating on a crisis footing when frontline staff need absolute clarity about ways of working.

4. We would therefore urge DHSC and NHSE/I) to seriously consider the extending the timetable for developing and implementing these proposals. Otherwise, there is a risk of unintended consequences within the legislation and in the design and practical implementation of ICSs simply thanks to limited engagement and consultation. This could jeopardise the shared ambition behind the proposals for a health and care system that can improve population health outcomes, tackle health inequalities, and deliver sustainable care for the future.

Working together and supporting integration proposals

5. NHSE/I put forward and consulted on a set of legislative proposals in 2019, and then consulted on a set of integrated care proposals in 2020. The white paper builds on these proposals, but in

some instances substantially redevelops them and in doing so, leaves important questions unanswered.

6. For example, the white paper creates a distinction between an ICS NHS body and an ICS health and care partnership. While the creation of a broader statutory partnership including local authorities and other public services, may well answer our concerns about whether system working would focus sufficiently on tackling health inequalities, this new proposal raises a series of other questions: it is currently unclear how these two component parts will work together in practice, and how to ensure that system governance reduces bureaucracy rather than adds further complication. It is unclear how NHS trusts and foundation trusts will relate to the ICS NHS body or the partnership and how the operational commissioning functions of CCGs will function in relation to the wider partnership as they become subsumed into the new ICS NHS body. We also have concerns about the extent to which the composition and governance of the board of the ICS NHS body be prescribed in legislation.

7. Clarity of accountabilities remains a particular concern. We understand the rationale behind the proposed two-part statutory model for ICSs, but it does create the distinct probability of unclear and duplicate accountabilities between the various bodies already in existence. By establishing an ICS NHS body and health and care partnership, in addition to health and wellbeing boards (HWBs), there are at least three potentially overlapping statutory boards for health and social care in each ICS. We are concerned that this complex playing field – in addition to integrated care partnerships / provider collaboratives, formal place level governance structures, trusts and foundation trusts, and PCNs – risks confusing accountabilities and adding further complication. There needs to be sufficient clarity on how all these different bodies, their roles and accountabilities fit together without duplication or overlap within an enabling legislative framework in which local system partners can agree the structures which work for their populations.

8. We welcome the confirmation that NHS trusts and foundation trusts will retain their current functions and duties “broadly as they are in current legislation”. However, we are again concerned to ensure the clarity around local accountabilities in the current legislation is maintained. For example, DHSC states that providers will retain their current organisational financial statutory duties, but there will be an additional duty on providers to have regard to the system financial objectives. We need to better understand how these two duties will work in practice and what mechanism will be in place to manage any conflicting priorities. As set out above, we also need to better understand how trusts and foundation trusts will retain their statutory functions in complement with the new ICS bodies.

9. Trust leaders are clear that the NHS capital system needs urgent reform. However, the legislative proposals for a reserve power to set a legally binding capital limit (CDEL) on individual named foundation trusts do not address the root of the problem arising from insufficient capital funding available in the system. The CDEL at a national level is too low for the NHS’ capital investment needs, and the allocation system is inadequate. Given the tensions in capital availability and

allocations, in 2019, NHSE/I agreed to a set of safeguards around the use of this reserve power. We are therefore very concerned that details on how the power would be used transparently are not included in the white paper. Previously, there was a commitment for NHSE/I to explain why the capital limit is necessary, describe what steps it had taken to avoid requiring its use and publish any representations from the foundation trust. NHS Providers would add to this, as we argued in 2019, that NHSE/I's reasoning should be published in Parliament.

10. Proposals around joint committees, collaborative commissioning and guidance on joint appointments, all represent a significant shift in approach. We recognise though that these mechanisms may provide trusts and their partners with practical, voluntary steps in support of system working. Trust leaders also support the reciprocal duty on NHS organisations and local authorities to collaborate, as well as the new triple aim, but it is important to note that an enabling environment and non-legislative factors will be more impactful in progressing the underlying intentions here. The secretary of state will also be able to issue guidance as to what delivery of this duty means in practice, and we would welcome greater clarity on what this might encompass.
11. We welcome the ambitions aimed at sharing data more effectively across the health and social care system. However, further dialogue is needed to ensure the proposals fully address the current problems associated with data sharing and management, including the ability of trusts to invest in technical infrastructure. Further information is also required in regard to the secretary of state's powers to mandate standards.

12. Some proposals will also need to be considered in light of the pandemic. For example, the white paper emphasises the importance of maintaining patient choice, but it is unclear how this will play out in the current circumstances of reducing the backlog of elective care and other services. The restoration and recovery of services will take many months, if not years, and DHSC needs to consider whether and how patient choice will be applicable in this instance. We agree with the recognition from DHSC that integration provides an opportunity to strengthen the patient voice and could build towards genuine co-production but note that this may be best shaped at a local level.

Reducing bureaucracy proposals

13. Trust leaders broadly view the current fragmented commissioning arrangements, competition rules and procurement processes as sub-optimal, and support the aim to align the legislative framework with collaborative ways of working.

14. The intention to move away from competitive retendering and burdensome procurement processes is positive, as is the principle of ICSs being able to continue existing provision and make arrangements without having to go through the bureaucracy of a competitive procurement process. However, it will be important to ensure that the right principles are applied to a robust process, with appropriate safeguards, and that local areas are supported to develop the strong relationships required to implement this new kind of commissioning. That

will include ensuring that trusts, and provider collaboratives are appropriately resourced if they take on some of the 'tactical' elements of commissioning and contracting often currently fulfilled by CCGs. Non-NHS providers are important partners for trusts, particularly in the community sector, and their role and services need to be supported where this is working well for local systems and populations.

15. We understand that amendments to the legislation relating to the national tariff support the broad policy direction towards system finances, and we are pleased that DHSC also intends to maintain the financial rigour and benchmarking that the tariff offers. We will work with NHSE/I and DHSC to understand the full implications of contested licence conditions or national tariff provisions no longer having to be referred to the Competition and Markets Authority (CMA).

16. The government will bring forward measures that will enable ICSs to apply to the secretary of state to create a new trust. Further clarity is needed around the intended use of this proposal: at present new NHS foundation trusts cannot be established from scratch and the 2012 Act did not envisage the creation of new NHS trusts. Given the complexity, financial and human resource, and the time taken to set up a new organisation at this scale and with this level of responsibility, we need to understand how this would be funded and implemented, how local consultation publicly and with the sector would operate, how the implications for existing trusts would be managed, and how the stability of the local health and care economy would be protected.

Ensuring accountability and public confidence proposals

17. Over the past two years, NHS England and NHS Improvement have increasingly come together and positive steps have been taken towards integrated system leadership of the NHS with increased coordination and consistency. However, we are concerned about the cumulative impact of the proposed enhanced powers of direction for the secretary of state over what would be the merged body of NHS England.

18. While we welcome DHSC's reassurance that the secretary of state will not be involved in day-to-day operations and that these powers would be rarely deployed, there needs to be further discussion about whether such broad powers are necessary and proportionate. We believe that the clinical and operational independence of the NHS is an important cornerstone of our health and care system, there is a potentially worrying trend within the proposals of the legislation allowing political overreach.

19. In addition, new powers for the secretary of state to transfer functions between arm's length bodies as well as to abolish them, represent a further significant centralisation of power and potential loss of independence for the NHS from political considerations. It is encouraging that these powers could only be exercised via a statutory instrument after formal consultation and approval from both Houses of Parliament, but we would encourage DHSC to provide safeguards to prevent Henry VIII clauses being used to circumvent due parliamentary process.

20. We would welcome further clarity regarding how workforce accountabilities are shared at national, regional and local levels. We note that the key issues of workforce shortages and future supply to meet demand remain unaddressed in the white paper.

Additional proposals to support social care, public health, and quality and safety

Social care

21. We agree that one piece of legislation cannot address all the challenges facing health and social care but would reiterate the importance of properly funding and reforming the social care system to ensure people get the care they need and stem the tide of increased demand on the NHS due to unmet or under-met need. We look forward to seeing the government's separate proposals on social care reform later this year.

22. We understand from the proposals that adult social care will have a greater voice in NHS planning and allocation through some representation on the ICS NHS body and through the wider statutory partnership. However, it remains unclear how the proposals truly address the original ambitions of bringing health and social care closer together at ICS level. Pooled budgets and guidance on joint appointments at place level are welcome, as this is where the majority of service integration will take place, but this does not fully address the wider strategic ambition of designing a more integrated health and social care system.

23. While we support the ambition to improve social care outcomes and co-produce a strengthened assurance framework for adult social care, we are concerned that the new powers of national intervention in the adult social care system are being developed without due consideration of the sustainable funding, and system reform, required by local authorities to deliver improvements in care.

24. We fully support the current discharge to assess model, and suspension of NHS Continuing Healthcare (CHC) assessments during the first wave of the pandemic, as well as the subsequent policy decision to postpone such assessments until after six weeks of centrally funded discharge care. The new legal framework proposed will require all NHS CHC and Care Act assessments to take place after an individual has been discharged from acute care. We are aware that primary legislation needs to be amended to embed these changes but encourage DHSC to only legislate for the minimal changes required (for example, removal of CHC) and consider with the community sector whether the new policy can be delivered through guidance.

Public health

25. The proposal for the secretary of state to have powers to direct NHS England to take on public health functions, alongside existing 7A provisions, raises questions about the future of the commissioning and provision of public health services. While the new provider selection regime appears to imply that some services will continue to be commissioned by local authorities, this new power suggests in future they may return to the NHS. Many NHS colleagues would welcome

greater oversight of the commissioning and delivery of more clinical preventative and public health services (such as drugs and alcohol, sexual health services etc). However, it will be essential to maintain local authority leadership in addressing the wider determinants of health, underpinned with sufficient investment. In the absence of a long-term funding settlement for public health, changes to the way services are commissioned will not alone resolve longstanding issues with their funding and delivery. Regardless of where these responsibilities sit, we believe that full and sustainable funding is essential to secure the effectiveness of public health services.

Quality and safety

26. We are concerned that the proposed secretary of state powers could mean senior NHS managers are subject to professional regulation in future. Statutory regulation of senior managers will not preclude the possibility that an individual with a good track record may make a bad decision or a mistake, nor can it prevent non-compliant behaviour. There is a danger that we place unrealistic expectations on what regulation can achieve, and when it fails to achieve this, we seek to regulate further rather than examine the drivers of poor leadership and put in place systems which support good governance.

27. NHS Providers welcomes the proposals to establish Health Services Safety Investigations Body (HSSIB) as an independent body to investigate incidents that may have an implication for the safety of patients. This is an important opportunity to help develop a just culture in the NHS and a focus on learning. However, the proposal for HSSIB to be established as an executive non-departmental public body does not appear to ensure its functional independence. The NHS' regulatory bodies are directly accountable to parliament, and the same arrangements should be in place for HSSIB.

28. We welcome DHSC's commitment to exploring ways to enhance the role of the Care Quality Commission (CQC) in reviewing system working, which is supported by trust leaders, but notice that there are no proposals to enhance CQC's remit at this stage. We look forward to working closely with CQC and NHSE/I on how ICSs will be held accountable for population health outcomes.

Conclusion

29. Many of the proposals in the white paper provide an important opportunity to accelerate local health and care integration, replacing competition with collaboration and reforming an unnecessarily rigid NHS approach to procurement. We are keen to understand the government's intentions on some of the new proposals it has added, such as the new powers for the secretary of state to direct NHS England, transfer powers between arm's length bodies, create new integrated trusts and intervene in local service reconfigurations. We also believe that it is vital to ensure that the proposed new statutory powers for ICSs avoid overlap and duplication with the

statutory powers of trusts and foundation trusts which will remain the key delivery mechanisms for ambulance, community, hospital and mental health care services.

This will be a wide-ranging Bill with far reaching implications for the health and care system and we look forward to working closely with the government to get the detail of these proposals right and ensure they contribute to improvements in care for patients and service users as intended.

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