The Health and Care Bill

House of Commons, Bill Committee, 14 September 2021 – consideration of clauses 1 - 25

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.

The majority of the Health and Care Bill (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. A comprehensive summary of key parts of the Bill as well as NHS Providers' views on those provisions can be found here.

We support the opportunity the Bill presents to design the right system architecture that will deliver sustainable high-quality care for the future. However we also believe there are improvements that can be made which will make this the transformative piece of legislation the government wants it to be.

Amendments covered in this briefing:

Clauses 1-11 (NHS England) and Schedule 1 (Renaming of NHS Commissioning Board)

- Amendment 18

Clauses 12-25 (Integrated Care Systems) and Schedule 2 (Integrated care boards: constitution etc)

- Amendment 49
- Amendment 38
- Amendment 48
- Amendment 50
- Amendment 51
- Amendment 52
- Amendment 32
- Amendment 7
- Amendment 8
- Amendment 47
- Amendment 53

Clauses 1-11 (NHS England) and Schedule 1 (Renaming of NHS Commissioning Board)

These clauses make a number of provisions concerning NHS England and its ways of working including: formally renaming the NHS Commissioning Board as 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 to NHS England (the key document setting out NHS England's priorities) in-year; and 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. Regulations may be made limiting this power. The ICB becomes liable for any tort arising from the direction.

NHS Providers' analysis

Amendment 18 (Clause 1)

Member's explanatory statement

This amendment changes the makeup of the Board [of NHS England] to acknowledge its new role in the integrated NHS and bringing representatives as non-executive members on the Board as with integrated care boards.

NHS Providers' view

It is the duty of boards of directors to lead and direct their organisation to represent the long-term interests of key stakeholders, but with a strong emphasis on the views of both service users and staff. Boards are responsible for carrying out the governance of an organisation: setting strategy; overseeing the implementation of strategy by supervising the executive and managing risk; setting and modelling organisational culture and ensuring that proper accountability arrangements are operative.

In the UK, boards in the NHS, in the private sector and increasingly in the third sector are unitary boards made up of executive and non-executive directors. All directors have joint and several responsibilities for every decision of the board regardless of their individual skills or status. This militates against non-executive directors such as the ordinary members of ICBs being nominees of a particular sector or interest group. It also militates against non-executive directors holding portfolios because every director has an equal responsibility in the boardroom, not a responsibility for or to a particular sector. All directors have a duty to ensure that all board decisions are subject to robust, but constructive, challenge and non-executive directors have a particular responsibility to ensure this happens. It is therefore crucial that they bring both independence and overt impartiality to the table. Once again, this militates against them being representatives or nominees beholden to other organisations.

Clauses 12–25 (Integrated Care Systems) and Schedule 2 (Integrated care boards: constitution etc)

The Bill introduces a two-part statutory integrated care system (ICS) model. ICSs will comprise:

- an integrated care board (ICB)[1], bringing together the organisations that plan and deliver NHS services within the geographic area covered by the ICS, and
- an integrated care partnership (ICP)[2], bringing together a broad alliance of organisations related to improving health and care.

NHS Providers' view

It is important that the Bill is enabling and permissive, in order to allow different systems flexibility in how they frame their arrangements to meet local needs. We believe that this can be achieved by defining the accountabilities of ICBs in three ways: firstly, to Parliament, via the Department of Health and Social Care and NHS England; secondly, to local communities; and thirdly, to their component organisations. At the moment, accountabilities are framed around only the first of these, but expanding those to whom ICBs must look will better ground them in their communities and keep focus on serving patients and service users.

Moreover, while we support the move to put ICBs on a statutory footing, we are still unclear how the relationships of local bodies fit together and align. We are also concerned about a lack of clarity in the legal duties, roles and responsibilities across the health and care system, including those of NHS

[1] The February 2021 *Integration and innovation* white paper called this part the ICS NHS Body.

[2] The white paper called this part the Health and Care Partnership.

England and the secretary of state. Given the nature and degree of power over ICSs and individual organisations that could be exerted under the Bill's proposals, it is essential to address these issues. Otherwise there is a risk of unclear accountabilities, confusion, stasis and duplication – and in turn, the potential for costly and time consuming judicial review proceedings.

It will be key to make crystal clear the relationship between trusts and ICBs, and how the statutory accountabilities of trusts, foundation trusts and ICBs align. There also needs to be clarity within the legislation on how the roles and responsibilities of the current NHS England and NHS Improvement (NHSE/I) regions, ICBs, ICPs, trusts, foundation trusts, health and wellbeing boards (HWBs), places, provider collaboratives, neighbourhoods and primary care networks (PCNs) will all fit together. To address this, we believe that the Bill needs to include the following:

1. A requirement to consult all trusts and foundation trusts within the ICB area (as well as primary care and local authorities) in developing the ICB composition and constitution;
2. Provision for a challenge mechanism for trusts and foundation trusts to raise concerns to NHS England about the ICB composition, constitution and plans if necessary/in extremis;
3. Safeguards around the power for NHS England to intervene directly in how ICBs exercise their functions, in particular setting out how ICB failure, or being at risk of failure, will be defined, assessed and determined; and
4. Clarity on how organisations will discharge their legal duties where there is potential for overlap (for example, ICBs will have a role in quality improvement – how does this align with the role of providers here?)

Our analysis on the amendments is based on how they fulfil the criteria we have set out above.

NHS Providers' analysis

Amendment 49 (Clause 13)

Member's explanatory statement

This amendment would ensure that trusts and local authorities are consulted before any changes are made to the number, shape and size of ICSs.

NHS Providers' view

Before varying or revoking an order under this section, the legislation as currently drafted requires NHS England to consult any integrated care board that it considers likely to be affected. No reference is made to trusts and foundation trusts.

We believe that trusts and foundation trusts should also be fully and properly consulted before any changes are made to the number, shape and size of ICSs. Trusts affected by recent ICS boundary changes were insufficiently consulted, but had significant concerns about the potential negative impacts on patient care that the changes represented. A robust consultation process must be written into the Bill.

Amendment 49 would ensure that trusts and foundation trusts must be fully and properly consulted before any changes are made to the number, shape and size of ICSs.

Amendment 38 (Clause 13)

Amendment 38 relates to clause 13 and proposes adding new reporting duties on ICBs and the secretary of state.

NHS Providers' view

This seems to introduce additional reporting burden into the system – ICBs will already be accountable to NHS England for designing and delivering their five year health plan, as well as the oversight of performance within the system. It also seems to increase the direct accountability of ICBs to the secretary of state, which exacerbates a common issue within the Bill of too great a focus being placed on accountability upwards rather than outwards to local populations and the ICS' constituent organisations.

Amendment 48 (Schedule 2)

Member's explanatory statement

This amendment would require ICBs to be clear about how they would make changes in clinical policies and established models of care that have already been established and are applicable to patients in the area for which the integrated care board takes responsibility.

NHS Providers' view

We believe it is important that ICBs consult all NHS providers within the ICB area (as well as primary care and local authorities) in key decisions, including in the development of the ICB's constitution and any changes to service delivery models.

Amendments 50, 51 and 52 (Schedule 2)

These amendments concern the constitution of ICBs. Amendment 50 removes the requirement for an ICB chair to be appointed with the approval of the secretary of state. Amendment 51 would make it a requirement for the ICB constitution to provide for consulting all members of the ICB before a chair is appointed. Amendment 52 intends to ensure the ICB and ICP are involved in the appointment of the ICB chief executive.

NHS Providers' view

We welcome the removal of wording in the Bill which calls for the chair of an ICB to be approved by the secretary of state. This will help to ensure that an ICB can operate as a well-functioning board by preventing political appointments and protecting the operational independence of the ICB

We believe that it is vital that the chair has the full confidence of the ICB and system partners and are concerned that collective confidence in an ICB could be undermined by an excessive top-down approach, which could also hinder the opportunity and ambition of system working. We agree that members of the ICB should be consulted prior to an ICB chief executive being appointed and the proposal that ICP members should also be consulted is welcome (although consideration would also need to be given to the practical implications here of an ICP's potentially sizeable membership).

Amendment 32 (Schedule 2)

Member's explanatory statement

This amendment would require integrated care boards to have members nominated by Directors of Public Health, mental health trusts, social care providers and trade union representatives and a member representing patients.

NHS Providers' view

There is a balance to strike between the need for an effective, streamlined board based on the principles of corporate governance and the need for constituent organisations to feel their voice is

heard in ICB decision-making. We agree that all provider types – including mental health, community, ambulance and acute trusts – must be involved in ICB decision-making. However, we also accept that there will be too many providers in most systems for them all to be a member of the ICB unitary board. A unitary board requires its members to act in the best interests of the ICS, not their 'home' organisation or sector and then to be severally and jointly liable for those decisions. There should however be a robust mechanism in each ICS to ensure that all constituent organisations are involved in ICB decision-making, as set out for providers in the model constitution for ICBS recently published by NHS England.

Amendment 7 (Clause 19)

Member's explanatory statement

This amendment would require Integrated Care Boards to work with universities to support research in their local health and care systems.

NHS Providers' view

The Bill places a duty on ICBs to have regard to the need to promote health research and use of evidence obtained from such research (e.g. to inform its commissioning plan). All trusts participate in research to some degree, as it is an integral part of the provision of clinical care. It therefore makes sense for research to be central to the mission of ICBs as well as for trusts. This amendment would create a more onerous duty on ICBs, which goes against the grain of creating a flexible enabling legislative framework.

Amendment 8 (Clause 19)

Member's explanatory statement

This amendment would require Integrated Care Boards to work with universities and other education providers to promote education and training in their local health and care systems.

NHS Providers' view

ICBs will take on a significant number of 'people' functions and responsibilities, including supporting staff health and wellbeing, growing future workforce supply and developing a system approach to education and training plans. In exercising these functions they will need to engage with local education providers. Regional people boards already bring together NHSE/I and Health Education England (HEE) with representatives from health, social care, local government and local education providers. It seems fitting that those boards should continue to work with universities and colleges to

promote the education and training of the research workforce. This amendment would in effect duplicate these regional structures and so appears to be unnecessary.

Amendment 47 (Clause 20)

Member's explanatory statement

This amendment would require the secretary of state to establish a procedure for the resolution of any dispute between an integrated care partnership and an integrated care board concerning the implementation of a strategy produced by the integrated care partnership.

NHS Providers' view

This amendment risks creating a hierarchical relationship when the ICB and ICP are meant to be two equal parts in the ICS governance infrastructure. The ICP will be responsible for creating the integrated care strategy, developed and supported by its constituent organisations. The ICB will be responsible for developing a five-year health plan with trusts and wider partners, which NHS England will hold it to account for delivering. The ICP should not have a role in holding the ICB to account as it risks confusing accountabilities. In addition, the ICP is envisaged as a strategic engagement forum that aligns strategies and shared priorities – it is not a performance manager. That said, we do accept that local partners will need to agree processes and procedures to resolve issues of difference and potential dispute – in line with good governance practice.

Amendment 53 (Clause 23)

Member's explanatory statement

This amendment would introduce an objection mechanism when an Integrated Care Board, Trust or Foundation Trust believes its capital resource limit or revenue resource limit risks compromising patient safety.

NHS Providers' view

As currently drafted, there is no objection mechanism in clause 23 (223M, Financial duties of integrated care boards: use of resources), despite there being a clear link between the funding available to a provider and its ability to deliver safe care. We therefore support the addition of a route of recourse when an ICB, trust or foundation trust considers that its capital resource limit or revenue resource limit risks compromising the safety of patients.