Report by Acting Chief Executive – monthly update: March 2021

Authors: Rebecca Brown and Stephen Ward Sponsor: Rebecca Brown **Trust Board paper E**

Purpose of report:

This paper is for:	Description	Select (X)
Decision	To formally receive a report and approve its recommendations OR a particular course of action	
Discussion	To discuss, in depth, a report noting its implications without formally approving a recommendation or action	X
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with treatment plan	
Noting	For noting without the need for discussion	

Previous consideration:

Meeting	Date	Please clarify the purpose of the paper to that meeting using the categories above
CMG Board (specify which CMG)	N/A	
Executive Board	N/A	
Trust Board Committee	N/A	
Trust Board	N/A	

Executive Summary

Context

The Acting Chief Executive's monthly update report to the Trust Board for March 2021 is attached.

Questions

Does the Trust Board have any questions or comments about our performance and plans on the matters set out in the report?

Conclusion

The Trust Board is asked to consider and comment upon the issues identified in the report.

Input Sought

We would welcome the Board's input regarding the content of this month's report to the Board.

For Reference:

This report relates to the following UHL quality and supporting priorities:

1. Quality priorities

Safe, surgery and procedures [Yes]
Improved Cancer pathways [Yes]
Streamlined emergency care [Yes]
Better care pathways [Yes]
Ward accreditation [Yes]

2. Supporting priorities:

People strategy implementation [Yes]
Investment in sustainable Estate and reconfiguration [Yes]
e-Hospital [Yes]
Embedded research, training and education [Yes]
Embed innovation in recovery and renewal [Yes]
Sustainable finances [Yes]

3. Equality Impact Assessment and Patient and Public Involvement considerations:

- What was the outcome of your Equality Impact Assessment (EIA)? N/A
- Briefly describe the Patient and Public Involvement (PPI) activities undertaken in relation to this report, or confirm that none were required – None Required.
- How did the outcome of the EIA influence your Patient and Public Involvement ? N/A
- If an EIA was not carried out, what was the rationale for this decision? On the basis that this is a monthly update report.

4. Risk and Assurance

Risk Reference:

Does this paper reference a risk event?	Select (X)	Risk Description:
Strategic: Does this link to a ***Principal Risk*** on the BAF?	**X**	ALL
Organisational: Does this link to an ***Operational/Corporate Risk*** on Datix Register	**X**	There are several risks which feature on the organisational risk register relating to matters covered in this paper.
New Risk identified in paper: What ***type*** and ***description***?	N/A	N/A
None		

5. Scheduled date for the **next paper** on this topic: April 2021 Trust Board
6. Executive Summaries should not exceed **5 sides** [My paper does comply]

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **4 MARCH 2021**

REPORT BY: **ACTING CHIEF EXECUTIVE**

SUBJECT: **MONTHLY UPDATE REPORT – MARCH 2021**

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1. Introduction

1.1 My report this month is confined to a number of issues which I think it important to highlight to the Trust Board.

2. UHL response to COVID-19

2.1 I will report orally at the Trust Board meeting on the current position.

2.2 I also wish to acknowledge the tremendous COVID-19 research work that is being undertaken at the Trust in partnership with the University of Leicester. Further details are set out in the quarterly research and innovation update report, which features elsewhere on this Board agenda, but it is worth underlining the local and national impact of recent studies concerning early PCR testing, antibodies studies and, more recently, the vaccination hesitancy in black and minority healthcare workers.

2.3 Team UHL is something special – going above and beyond time and time again. The pandemic has placed certain areas of the hospitals under much greater pressure than others and everyone has rallied to ensure we have the right support in the right places

2.4 People across our hospitals have stepped out of their comfort zone, stepped into new roles and stepped up to the challenges to help wherever and however they can. We have eminent Professors working as Healthcare Assistants in intensive care. We have research nurses working alongside our clinical teams. We have people from clinical backgrounds who usually work in corporate roles, supporting those in the clinical field. We also have GP trainees, medical and nursing students working alongside us and, for the past few weeks, members of the Army too. For many of them, this is the first time they are working in these environments. The redeployment efforts are phenomenal and are a vital part of our ongoing Covid response.

2.5 Over the course of the last two weeks, some of our staff have been sharing their stories in our internal communications, on the local radio, TV and via our social media channels. These wonderful stories have given a great insight into the challenges and opportunities redeployment brings. They are just a handful of examples of the amazing collaboration and team spirit we have seen across our hospitals as we all strive to give the best possible care to our patients.

2.6 The importance of staff resilience was identified in the reframed NHS Long Term Plan but the outbreak of COVID-19 has made the need all the more urgent. We are committed to supporting all staff and I am delighted to say that, in response to the pandemic, and as set out in our LLR People Plan, we have committed to establishing a first wave Mental Health and Wellbeing Hub to support the health and social care workforce across organisations in LLR, in order to facilitate timely access to appropriate psychosocial interventions in a stepped model.

2.7 A presentation on this development was made to the People, Performance and Process Committee last week, and the discussion at that meeting is set out in the summary which features elsewhere on today's Board agenda.

3. Quality and Performance Dashboard – January 2021

3.1 The Quality and Performance Dashboard for January 2021 is appended to this report at **appendix 1.**

3.2 The Dashboard aims to ensure that Board members are able to see at a glance how we are performing against a range of key measures.

3.3 The more comprehensive monthly Quality and Performance report has been reviewed as part of the deliberations of the February 2021 meetings of the People, Process and Performance Committee and Quality and Outcomes Committee, respectively. The month 10 quality and performance report is published on the Trust's website.

3.4 ***Good News***

- **Mortality** – the latest published SHMI (period October 2019 to September 2020) is 100, and remains within the expected range.
- **CAS alerts** - compliant.
- **C DIFF** – 8 cases reported this month.
- **90% of Stay on a Stroke Unit** – threshold achieved with 86.3% reported in December.
- **Fractured neck of femurs operated 0-35hrs** – performance is above target at 75.8%.
- **VTE** – compliant at 98.7% in January.
- **TIA (high risk patients) –** 67.1% reported in January
- **Cancer Two Week Wait** was 94.8% in December against a target of 93%.
- **Cancer Two Week Wait (Symptomatic Breast)** was 95.1% in December against a target of 93%.

3.5 ***Bad News***

- **MRSA** – 1 case reported.
- **UHL ED 4 hour performance** – 63.9% for January, system performance (including LLR UCCs) for January is 74.5%.
- **Ambulance Handover 60+ minutes (CAD)** – performance at 10.9%.
- **12 hour trolley wait -** 17 breaches reported.

- **Cancer 31 day treatment** was 94.7% in December against a target of 96%.
- **Cancer 62 day treatment** was 73.6% in December against a target of 85%.
- **Referral to treatment** – the number on the waiting list (now the primary performance measure) was above the target and 18 week performance was below the NHS Constitution standard at 56.3% at the end of January.
- **52+ weeks wait –** 8,424 breaches reported in January.
- **Diagnostic 6 week wait** was 44.3% against a target of 1% in January.
- **Patients not rebooked within 28 days following late cancellation of surgery –** 39.
- **Cancelled operations OTD** –1.1% reported in January.
- **Statutory and Mandatory Training** is at 87%.
- **Annual Appraisal** is at 79.4%.

4. Department of Health and Social Care (DHSC) Legislative Proposals for a Health and Care Bill and NHSI/E Legislation recommended to Government and Parliament

4.1 On 11th February 2021, the DHSC published a White Paper setting out legislative proposals for a Health and Care Bill.

4.2 On the same day, NHSE/I also published a paper, 'Legislating for integrated care systems: five recommendations to Government and Parliament', setting out the feedback received from the Integrating Care engagement exercise, and setting out key legislative proposals in response to the feedback. DHSC has accepted those proposals, and incorporated them into the aforementioned White Paper.

4.3 Finally, NHSE/I has also published its consultation on proposals for a new Provider selection regime, which set out a new approach to procuring healthcare services.

4.4 Further details are set out in the NHS Providers' briefing, attached at **appendix 2.**

4.5 The proposals will be the subject of further discussion at a forthcoming Board Development Session.

5. EU Exit

5.1 The United Kingdom (UK) officially left the European Union (EU) at 11pm on 31 January 2020, at which point it entered a "transition period" whereby it could continue its relationship with the EU while a future trading relationship and security cooperation could be agreed. The resulting Trade Deal Agreement between the UK and the EU was announced on 24 December 2020 and came into effect at 11pm on 31 December 2020.

5.2 In preparation for potential impacts at the end of the transition period, the Trust created an EU Exit Planning Group in February 2019 to support the management of any risks associated with EU Exit. The EU Exit Planning Group included representatives from a number of priority work streams identified by the Department of Health and Social Care (DHSC) and NHS England & NHS Improvement (NHSEI). The EU Exit Planning Group was supported by the Accountable Emergency Officer (AEO) for EU Exit, the Acting Chief Executive.

5.3 As part of its preparative work, the EU Exit Planning Group developed contingency plans against a reasonable worst case scenario provided by DHSC. Following the announcement of the Trade Deal Agreement, the Trust received details from DHSC and NHSEI on the likely impacts which the NHS could expect to encounter as a result of the agreed deal. The severity of these impacts is less than those described in the reasonable worst case planning scenario and consequently the EU Exit Planning Group is assured the contingency plans it has developed are sufficient and robust.

5.4 To date, the Trust has encountered only minor impacts arising from EU Exit and these have been quickly resolved. The Trust recognises that additional impacts may arise in the future and these will be identified and monitored through the UHL COVID-19 Tactical Group which is continuing to meet on a regular basis at this time.

6. Joint Accreditation Group (JAG) on GI Endoscopy – Glenfield Hospital

6.1 I am pleased to confirm that, following an annual review, this service has met all of the required accreditation standards and accreditation has been renewed until 1st November 2021.

6.2 Accreditation is awarded for five years, subject to successful completion of an annual review, and I am pleased to congratulate the clinical team and their colleagues for their high standard of achievement, and for their hard work during the accreditation process.

7. Mr Atul Bagul – Head of Transplant Service, UHL

7.1 I am pleased to report that Mr Atul Bagul, Head of Transplant Service, UHL has been awarded the 'Excellence In Delivering Patient Care' award by the National Blood and Transplantation Society.

7.2 The award reflects Mr Bagul's dedication and commitment to the transplant programme locally and nationally, and I am sure that Board colleagues will join me in congratulating Mr Bagul on this fine achievement.

8. Conclusion

8.1 The Trust Board is invited to consider and comment upon this report and the attached appendices.

Rebecca Brown
Acting Chief Executive

26th February 2021

Quality and Performance Report Board Summary January 2021

This dashboard uses icons to indicate if a process is showing special cause or common cause variation. It also indicates whether the process is able to meet any stated target. Here is a key to the icons

Icon	Description
H	Special cause variation - cause for concern (indicator where high is a concern)
L	Special cause variation - cause for concern (indicator where low is a concern)
	Common cause variation
H	Special cause variation - improvement (indicator where high is good)
L	Special cause variation - improvement (indicator where low is good)

These icons are used to indicate statistical variation. We have identified special cause variation based on three rules which are shown below. If none of the rules are present then the metric is showing common cause variation.

- An upwards or downwards trend in performance for seven or more consecutive months.
- Seven or more months above or below the average.
- One month or more outside the control limits .

Icon	Description
F	The system is expected to consistently fail the target
P	The system is expected to consistently pass the target
?	The system may achieve or fail the target subject to random variation

These icons are used to indicate if a target is likely to be achieved next month, has the potential to be achieved or is expected to fail.

Green indicates that the metric has passed the monthly or YTD target while **Red** indicates a failure to do so.

The trend shows performance for the most recent 13 months.

Data Quality Assessment – The Data Quality Forum panel is presented with an overview of data collection and processing for each performance indicator in order to gain assurance by best endeavours that it is of suitably high quality. The forum provides scrutiny and challenge on the quality of data presented, via the attributes of (i) Sign off and Validation (ii) Timeliness and Completeness (iii) Audit and Accuracy and (iv) Systems and Data Capture to calculate an assurance rating.

Quality and Performance Report Board Summary January 2021

Domain	KPI	Target	Nov-20	Dec-20	Jan-21	YTD	Assurance	Variation	Trend	Data Quality Assessment
Safe	Never events	0	0	2	0	6				Jan-20
	Overdue CAS alerts	0	0	0	0	0				Nov-19
	% of all adults VTE Risk Assessment on Admission	95%	98.2%	98.6%	98.7%	98.5%				Dec-19
	Emergency C-section rate	No Target	24.1%	22.0%		20.8%				Feb-20
	Clostridium Difficile	108	7	3	8	65				Nov-17
	MRSA Total	0	0	0	1	1				Nov-17
	E. Coli Bacteraemias Acute	No Target	12	5	7	77				Jun-18
	MSSA Acute	No Target	3	2	4	26				Nov-17
	COVID-19 Community Acquired <= 2 days after admission	No Target	76.6%	56.4%	65.7%	71.3%				Oct-20
	COVID-19 Hospital-onset, indeterminate, 3-7 days after admission	No Target	9.6%	19.5%	15.1%	12.3%				Oct-20
	COVID-19 Hospital-onset, probable, 8-14 days after admission	No Target	6.4%	14.8%	11.3%	9.4%				Oct-20
	COVID-19 Hospital-onset, healthcare-acquired, 15 or more days after admission	No Target	7.4%	9.4%	7.9%	7.0%				Oct-20
	All falls reported per 1000 bed days	5.5	4.2	4.6		4.6				Oct-20
	Rate of Moderate harm and above Falls PSIs with finally approved status per 1,000 bed days	No Target	0.02	0.13		0.09				Oct-20

Domain	KPI	Target	Nov-20	Dec-20	Jan-21	YTD	Assurance	Variation	Trend	Data Quality Assessment
Caring	Staff Survey Recommend for treatment	No Target	Reporting will commence once national reporting resumes							Aug-17
	Single Sex Breaches	0	National reporting commences in April 2021							Mar-20
	Inpatient and Day Case F&F Test % Positive	TBC	99%	98%	98%	98%				Mar-20
	A&E F&F Test % Positive	TBC	94%	95%	93%	95%				Mar-20
	Maternity F&F Test % Positive	TBC	97%	96%	96%	97%				Mar-20
	Outpatient F&F Test % Positive	TBC	95%	94%	95%	94%				Mar-20
	Complaints per 1,000 staff (WTE)	No Target								Jan-20

Domain	KPI	Target	Nov-20	Dec-20	Jan-21	YTD	Assurance	Variation	Trend	Data Quality Assessment
Well Led	Staff Survey % Recommend as Place to Work	No Target	Reporting will commence once national reporting resumes							Sep-17
	Turnover Rate	10%	9.5%	8.9%	8.8%	8.8%				Nov-19
	Sickness Absence	3%	7.8%	7.6%		7.0%				Oct-16
	% of Staff with Annual Appraisal	95%	82.8%	82.2%	79.4%	79.4%				Dec-16
	Statutory and Mandatory Training	95%	88%	88%	87%	87%				Feb-20
	Nursing Vacancies	No Target	12.6%	12.8%	12.9%	12.9%				Dec-19

Quality and Performance Report Board Summary January 2021

Domain	KPI	Target	Nov-20	Dec-20	Jan-21	YTD	Assurance	Variation	Trend	Data Quality Assessment
Effective	Mortality Published SHMI	100	98	99	100	100 (Oct 19 to Sep 20)				Sep-16
	Mortality 12 months HSMR	100	103	104	105	105 Nov 19 to Oct 20				Sep-16
	Crude Mortality Rate	No Target	1.8%	2.3%	3.3%	1.9%				Sep-16
	Emergency Readmissions within 30 Days	8.5%	8.8%	9.1%		9.5%				Sep-20
	Emergency Readmissions within 48 hours	No Target	1.0%	1.1%		1.2%				Sep-20
	No of #neck of femurs operated on 0-35hrs	72%	64.9%	68.1%	75.8%	65.8%				Sep-20
	Stroke - 90% Stay on a Stroke Unit	80%	89.7%	86.3%		86.7%				Mar-20
	Stroke TIA Clinic Within 24hrs	60%	82.5%	79.5%	67.1%	69.8%				Mar-20

Domain	KPI	Target	Nov-20	Dec-20	Jan-21	YTD	Assurance	Variation	Trend	Data Quality Assessment
Responsive	ED 4 hour waits UHL	95%	68.5%	67.0%	63.9%	73.7%				Mar-20
	ED 4 hour waits Acute Footprint	95%	77.6%	75.9%	74.5%	81.6%				Aug-17
	12 hour trolley waits in A&E	0	5	7	17	32				Mar-20
	Ambulance handover >60mins	0.0%	9.6%	9.6%	10.9%	4.9%				TBC
	RTT Incompletes	92%	59.6%	58.7%	56.3%	56.3%				Nov-19
	RTT Waiting 52+ Weeks	0	5248	6361	8424	8424				Nov-19
	Total Number of Incompletes	66,397 (by year end)	75,886	78,011	80,593	80,593				Nov-19
	6 Week Diagnostic Test Waiting Times	1.0%	31.1%	35.3%	44.3%	44.3%				Nov-19
	Cancelled Patients not offered <28 Days	0	14	32	39	226				Nov-19
	% Operations Cancelled OTD	1.0%	1.2%	1.1%	1.1%	0.9%				Jul-18
	Long Stay Patients (21+ days)	70	154	175	175	175				Sep-20
	Inpatient Average LOS	No Target	3.7	3.6	3.3	3.6				Sep-20
	Emergency Average LOS	No Target	5.1	5.2	5.6	4.9				Sep-20

Domain	KPI	Target	Oct-20	Nov-20	Dec-20	YTD	Assurance	Variation	Trend	Data Quality Assessment
Responsive - Cancer	2WW	93%	90.4%	93.3%	94.8%	91.2%				Dec-19
	2WW Breast	93%	96.9%	95.2%	95.1%	95.7%				Dec-19
	31 Day	96%	93.5%	93.1%	94.7%	92.0%				Dec-19
	31 Day Drugs	98%	100%	100%	100%	99.8%				Dec-19
	31 Day Sub Surgery	94%	77.4%	77.4%	74.3%	73.5%				Dec-19
	31 Day Radiotherapy	94%	96%	95.6%	94.4%	92.3%				Dec-19
	Cancer 62 Day	85%	70.4%	79.2%	73.6%	70.8%				Dec-19
	Cancer 62 Day Consultant Screening	90%	78.9%	85.5%	97.0%	69.1%				Dec-19

Domain	KPI	Target	Nov-20	Dec-20	Jan-21	YTD	Assurance	Variation	Trend	Data Quality Assessment
Outpatient Transformation	% DNA rate	No Target	6.7%	6.6%	6.9%	6.4%				Feb-20
	% Non Face to Face Appointments	No Target	47.5%	45.8%	50.0%	54.7%				Feb-20
	% 7 day turnaround of OP clinic letters	90%	84.8%	75.4%	84.0%	86.5%				Feb-20

11 February 2021

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

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

The Department of Health and Social Care (DHSC) has today published its White Paper, *"Integration and Innovation: working together to improve health and social care for all – Department of Health and Social Care's legislative proposals for a Health and Care Bill"*. This briefing summarises key content from the White Paper as well as NHS Providers' initial views and analysis of the proposals most affecting trusts.

Today's White Paper marks an evolution of the proposals for legislative change originally brought forward by NHS England and NHS Improvement (NHSE/I) in Autumn 2019 following an engagement process with key stakeholders including NHS Providers, and NHSE/I's subsequent recent engagement process on *Integrating Care* with regard to system working. As our briefing sets out, the White Paper covers considerable ground and includes a number of provisions not previously considered by the sector. We will be prioritising our engagement around the White Paper, and the subsequent Bill on your behalf. If you have any feedback on this briefing or the White Paper, please contact Cath Witcombe, Public Affairs Manager, catherine.witcombe@nhsproviders.org and Georgia Butterworth, Policy Advisor (Systems), georgia.butterworth@nhsproviders.org

Overall positioning

DHSC makes the case for the current legal framework to be improved to support the NHS recovery from the pandemic and to meet future challenges. Today's White Paper marks an evolution of the proposals for legislative change originally brought forward by NHS England and NHS Improvement (NHSE/I) in Autumn 2019 following an engagement process with key stakeholders including NHS Providers, and NHSE/I's subsequent recent engagement process on *Integrating Care* with regard to

system working. Overall the paper covers considerable ground and also includes a number of new provisions not included in NHSE/I's thinking which will require full engagement.

The DHSC emphasises the fact that it has sought to develop the legislative proposals with the whole health and care system in mind to realise the ambition of reducing inequalities and supporting people to live longer, healthier and more independent lives. The purpose of the legislation set out is to create an enabling framework for local partners to build upon existing partnerships at place and system levels, and to align services and decision making in the interests of local people. In addition to closer working at a local and system level, the White Paper refers to new, 'proportionate national legislative intervention on public health measures'. The three factors that frame the government's proposed approach are:

1. The importance of shared purpose within places and systems;
2. The recognition of variation – some of it warranted – of form and in the potential balance of responsibilities between places and the systems they are part of;
3. The reality of differential accountabilities, including the responsibility of local authorities to their elected members and the need for NHS bodies to be able to account for NHS spend and healthcare delivery and outcomes.

The government reiterates its intention to bring forward separate proposals on social care later this year.

Summary of NHS Providers Views

Overall, trust leaders will welcome 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 their system partners for several years in sustainability and transformation partnerships (STPs) and then 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. We also welcome confirmation that as expected the statutory basis of trusts and foundation trusts will remain 'broadly unchanged' as the key unit of delivery for acute, mental health, ambulance and community services. Trusts' role as the leaders and co leaders of system working, will continue to evolve in this new context.

In general, trust leaders also 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.

That said, the significance of any move to amend the legislative framework within which the NHS operates cannot be understated. The proposals in the White Paper to strengthen system working do build on a clear legacy but still amount to a significant structural, and cultural shift in ways of working within the health and care sector – at a time of unprecedented operational pressure.

The White Paper also sets out a number of proposals which seem to cumulatively amount to far-reaching powers for the secretary of state. This includes greater powers of direction over NHS England, 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 new proposed powers.

There is a lot of detail to get right in what is now a wide-ranging Bill. We urge DHSC and NHSE/I to set out clearly a list of regulations that need retaining or replacing, and an assessment of the potential costs, savings and patient benefits associated with legislative change of the scale proposed in the next phase of Bill development.

One key issue for further discussion is how quickly these legislative changes can be implemented, given the immediate operational pressures the NHS is currently facing, including COVID-19 hospitalisations, maintaining non-COVID care and delivering the vaccination programme – which will remain a significant undertaking over the next six months at least. Staff will then need time to recover before the NHS turns its attention to recovering elective care and other services, which again will last many months – if not years. NHS Providers will urge DHSC and NHSE/I to seriously consider the timing of these proposals.

The scope, scale and pace of these changes, in the middle of the pandemic, mean it is more important than ever to engage trusts and their system partners in the policy development and Bill drafting process. The proposed changes are complex and must be carefully worked through with the sector to avoid unintended consequences. The consensus created around NHSE/I's 2019 proposals was helpful in terms of getting overall support from the health and care sector, which is essential for successful implementation. We encourage DHSC to replicate this forum.

Proposals for legislation

Working together and supporting integration proposals

Establishing Integrated Care Systems

The government is proposing to implement NHSE/I's recommendations in their recent *Legislating for Integrated Care Systems* document and legislate for every part of England to be covered by an ICS. The statutory ICS will be comprised of an ICS NHS Body (subsuming CCG functions and several NHSE commissioning functions for specialised commissioning, primary care and other directly commissioned services) and a separate ICS Health and Care Partnership (together referred to as the ICS), to strengthen the decision-making authority of the system leadership and to embed accountability for system performance into the NHS accountability structure. This dual structure aims to recognise that there are two forms of integration required – both within the NHS and between the NHS and its partners, including local authorities. ICSs will be accountable for population health outcomes.

The ICS NHS body will be responsible for:

- Developing a plan to meet the health needs of the population within their defined geography;
- Developing a capital plan for the NHS providers within their health geography;
- Securing the provision of health services to meet the needs of the system population.

The ICS would have the ability to delegate functions to provider collaboratives and places (facilitated by proposals for joint committees).

To support the ambition for ICSs to improve population health outcomes and tackle health inequalities, the ICS Health and Care Partnership will bring together health, social care, public health (and potentially representatives from the wider public space where appropriate, such as social care/housing providers). This body will be responsible for developing a plan that addresses the wider health, public health, and social care needs of the system – the NHS ICS Body and local authorities will have to have regard to that plan when making decisions. The two parts of the ICS will be given the flexibility to develop processes and structures which work most effectively for them. The ICS Health and Care Partnership could also be used by NHS and local authority partners as a forum for agreeing co-ordinated action and alignment of funding on key issues, and this may be particularly useful in the early stages of ICS formation.

An ICS will be expected to work closely with health and wellbeing boards (HWB) and the NHS ICS Body will be required to have regard to the joint strategic needs assessments (JSNAs) and joint health and wellbeing strategies that are being produced at HWB level (and vice versa).

Importantly, NHS trusts and foundation trusts will remain "separate statutory bodies with their functions and duties broadly as they are in the current legislation". The ICS NHS body will not have the power to direct providers. NHS England will have the power to set financial allocations and financial objectives at system level. There will be a duty placed on the ICS NHS body to meet the system financial objectives which require financial balance to be delivered. NHS providers within the ICS will retain their current organisational financial statutory duties. The ICS NHS Body will not have the power to direct providers, and providers' relationships with the Care Quality Commission will remain unchanged. However this will also be supplemented by a new duty to compel providers to have regard to the system financial objectives so both providers and ICS NHS bodies are "mutually invested in achieving financial control at system level."

Duty to Collaborate

Alongside the creation of statutory ICSs, the government intends to introduce a new duty to promote collaboration across the healthcare, public health and social care system. This proposal will place a duty to collaborate on NHS organisations (both ICSs and providers) and local authorities. The secretary of state will have the ability to issue guidance as to what delivery of this duty means in practice. This proposal will replace the two existing statutory duties to cooperate.

Triple Aim

Trusts, ICSs and NHSE will be required to have regard to the 'Triple Aim' of better health and wellbeing for everyone, better quality of health services for all individuals, and sustainable use of NHS resources. This proposal aims to support collaboration in the best interest of the population and address the wider determinants of health.

Reserve power over foundation trusts capital spend limits

The government plans to implement NHSE/I's recommendation for a reserve power to set a legally binding capital spending (CDEL) limit on individual, named foundation trusts.

DHSC states that this will be used when "trusts are not working effectively to prioritise capital expenditure within their ICS, and risk breaching either system or national CDEL limits." DHSC adds that "this is not a general power to direct all foundation trusts on capital spending and is not intended

to erode foundation trust autonomy, but it is designed to be used in targeted ways to support the work of ICSs."

Joint committees

The government proposes accepting NHSE/I's recommendation to allow (1) CCGs/ICSs and NHS providers and (2) groups of NHS providers to create joint committees. Legislation does not currently allow these bodies to take joint decisions. Both types of joint committees could include representation from other bodies such as primary care networks, GP practices, local authorities or the voluntary sector.

Collaborative Commissioning

The government intends to implement NHSE/I's recommendation to change the legislation to remove barriers to working collaboratively and to make decision making and the pooling of budgets between CCGs and NHS England, across CCGs, and between CCGs and local authorities, more streamlined.

These proposals will:

- Give NHS England the ability to joint commission its direct commissioning functions with more than one ICS Board
- Allow ICSs to enter into collaborative arrangements to exercise their delegated functions "enabling a double-delegation"
- Allow groups of ICSs to use joint and lead commissioner arrangements to make decisions and pool funds across all their functions.
- Enable NHS England to delegate section 7A public health services, including to collaborative arrangements.
- Enable NHS England to delegate or transfer the commissioning of certain specialised services to ICSs singly or jointly, or for NHS England to jointly commission these services with ICSs if these functions are considered suitable for delegation or joint commissioning subject to certain safeguards. Specialised commissioning policy and service specifications will continue to be led at a national level ensuring patients have equal access to services across the country.

Joint Appointments

In line with NHSE/I's recommendation, the government is proposing to introduce a specific power for NHSE/I to issue guidance on joint appointments between NHS bodies; NHS bodies and local authorities; and NHS bodies and combined authorities.

Data Sharing

The forthcoming data strategy for health and care will set out a range of proposals to address cultural, behavioural and legislative barriers to data sharing and a more flexible legislative framework to improve data access and interoperability, including enabling the safe sharing of data in support of individual care, population health and the effective functioning of the system.

As part of this work, the government is exploring where achieving these objectives may require primary legislation, including proposals to require health and adult social care organisations to share anonymised information, introduce powers for secretary of state to require data from all registered adult social care providers, introduce a duty on NHS Digital to consider the benefits of data sharing when exercising its functions, and introduce a power for secretary of state to mandate standards for how data is collected and stored.

Patient Choice

As part of its package of changes to procurement policy, the government is proposing to repeal section 75 of the Health and Social Care Act 2012 including Procurement, Patient Choice and Competition Regulations 2013 and replace the powers in primary legislation under which they are made with a new provider selection regime. Under the new model, decision-making bodies (ICSs, providers, groups of providers etc) will be required to protect, promote and facilitate patient choice with respect to services or treatment.

The government also wants to clarify rules, circumstances and processes around the operation of Any Qualified Provider (AQP) and intend to take forward the NHS's recommended approach by retaining existing patient choice rights and protections and strengthening the process for AQP arrangements. The government says that it will also work closely with the NHS to reduce the health inequalities currently experienced in the area of choice, by helping to increase clarity and awareness of patient choice rights within systems and of the range of choices available.

NHSE/I published proposals for a new provider selection regime today, which are out for consultation until 7 April.

NHS Providers View

Placing ICS on a statutory footing

The new proposal for ICSs to be comprised of a wider health and care partnership to help tackle population health and health inequalities, as well as a more narrowly focused, statutory ICS NHS body, helpfully addresses our concerns that the multiple objectives of an ICS (as proposed in NHSE/I's *Integrating Care* paper) may not be compatible. However, this proposal does raise new questions about how the two bodies will work effectively together in practice and ensure system governance reduces bureaucracy rather than adds further complication. It is also unclear whether NHS trusts and foundation trusts will report into the ICS NHS body, and how in practice CCG operational commissioning functions will be subsumed into this and/or the wider partnership.

Legislation should allow flexibility for individual ICSs to determine how the NHS ICS Body is comprised, and we will review with members whether the current proposals for trust, local authority and general practice membership should be prescribed on the face of the Bill or whether this is unwelcome proscription. We are concerned that a complex playing field of ICSs, Integrated Care Partnerships / provider collaboratives, formal place level governance structures, trusts and foundation trusts and PCNs risks confusing accountabilities. As this proposal for ICSs is a combination of the two options that NHSE/I recently consulted on in the *Integrating Care* paper, and has not been subject to consultation itself, we will discuss the proposal and its implications with trust leaders and colleagues on DHSC and NHSE/I.

We welcome DHSC's recognition of the heterogeneity of ICSs/STPs, which has clearly influenced its legislative proposals. It may be that the implementation timetable for putting ICSs on a statutory footing in 2022 needs to be reconsidered or some other flexibility built into the legislation, such as a shadow form or deferred commencements, to ensure that all systems are ready before they take on statutory functions. Many trust leaders are concerned that while collaboration is essential to post-Covid restoration and recovery (for example, tackling waiting lists for elective care and other services), distracting legislative change could hinder the NHS in addressing its post-COVID challenges.

We particularly 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 will need to closely scrutinise further detail 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 welcome further clarity about how these two duties will work in practice and what mechanism will be in place to manage any conflicting priorities. It is vital that proposed new statutory powers for ICSs avoid overlap and duplication with those of trusts and foundation trusts.

Proposed powers to direct FT capital expenditure

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, does not address the root of the problem. The CDEL at a national level is too low for the NHS' capital investment needs, and the allocation system is inadequate.

In 2019, NHS Providers carefully negotiated a number of safeguards to restrict this proposal within the recommendations NHSE/I originally put forward. We are therefore extremely concerned that details on how the power would be used transparently are not included in the White Paper, as agreed in the 2019 recommendations. This includes 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. In September 2019, we stated our clear preference that NHSE/I's reasoning should be published in Parliament. Transparency must not be lost and we will be pushing for this to be explicitly reflected in the Bill.

Joint committees, collaborative commissioning and joint appointments

DHSC's proposals around joint committees, collaborative commissioning and guidance on joint appointments, all represent a significant shift in approach but may provide trusts and their partners with practical, voluntary steps in support of system working. While trust leaders support the reciprocal duty to collaborate on NHS organisations and local authorities, as well as the new Triple Aim, they emphasise that the enabling framework/environment and non-legislative factors will be more impactful than any duty (which arguably exists already in the duty to cooperate). We would welcome more clarity about the secretary of state's ability to issue guidance as to what delivery of this duty means in practice. *Data sharing*

We welcome the ambitions aimed at sharing data more effectively across the health and social care system, given the government's goal to reduce bureaucracy. We know that data requests and record management are often cited by staff as a bureaucratic burden which distracts from patient care. However, we would welcome further dialogue around some of the specific proposals to ensure that

they fully address the current problems associated with data sharing and management, including the ability of trusts to invest in technical infrastructure. We would also welcome further information and clarity in regard to the secretary of state' powers to mandate standards.

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 patient voice and could build towards genuine co-production, but note that this may be best shaped at a local level.

Reducing bureaucracy

Competition

The government intends to take forward proposals to replace the principle of competition with collaboration in legislation, including:

- Remove the Competition and Market Authority (CMA) function to review mergers involving NHS foundation trusts. The CMA's jurisdiction in relation to transactions involving non-NHS bodies (for example between an NHS trust/foundation trust and private enterprise) and other health matters (for example, drug pricing) would be unchanged.
- Remove NHS Improvement's specific competition functions and its general duty to prevent anti-competitive behaviour
- Remove the need for NHS England to refer contested licence conditions or National Tariff provisions to the CMA.

Arranging healthcare services

The government proposes to remove current procurement rules which apply for NHS and public health commissioners when arranging healthcare services. Powers will be created to remove the commissioning of these services from the scope of the Public Contracts Regulations 2015, as well as repealing Section 75 of the Health and Social Care Act 2012 and the Procurement, Patient Choice and Competition Regulations 2013.

The government wishes to develop a new provider selection regime, which will provide a framework for NHS bodies and local authorities to follow when deciding who should provide healthcare service. This will allow commissioners more discretion over when to use procurement processes than at present. Voluntary and independent sector providers will continue to play an important role, but

where there is no value in running a competitive procurement process (e.g. A&E provision), services will be able to be arranged with the most appropriate provider.
A consultation on the provider selection regime has been launched by NHSE/I today and we will respond on your behalf

These reforms will only apply to the arrangement of healthcare services. This includes public health services, whether commissioned solely by a local authority or jointly by the local authority and NHS as part of a Section 75 agreement. The procurement of non-clinical services, such as professional services or clinical consumables, will remain subject to Cabinet Office public procurement rules.

National tariff

The government will take forward NHSE/I's proposals on the national tariff, amending legislation to "enable the national tariff to support the right financial framework for integration whilst maintaining the financial rigour and benchmarking that tariff offers." This includes:

- Where NHS England specifies a service in the national tariff, then the national price set for that service may be either a fixed amount or a price described as a formula
- NHS England could amend one or more provisions of the national tariff during the period which it has effect, with appropriate safeguards
- Remove the requirement for providers to apply to NHS Improvement for local modifications to tariff prices
- NHS England should be able to include provisions in the National Tariff on pricing of NHS public health services where exercising public health functions delegated by the secretary of state.

The government also plans to remove the need for NHS England to refer contested licence conditions or national tariff provisions to the CMA.

New Trusts

DHSC proposes a new power for secretary of state to create new trusts. This takes NHSE/I's original recommendation for a power to create new integrated trusts further. ICSs will be able to apply to the secretary of state to create a new trust. This decision will be subject to engagement and consultation, set out in guidance.

Removing Local Education Training Boards (LETBs)

The government is proposing to remove LETBs from statute in order to provide HEE with the flexibility to adapt its regional operating model over time.

NHS Providers View

Competition, procurement and tariff

There is strong support from trust leaders for the ambition to replace competition with collaboration as the principle driving improvement in the NHS. We support the intention to move away from competitive retendering and burdensome procurement processes, as well as the principle of CCGs and then ICSs being able to decide to continue with existing providers/make arrangements with the most suitable provider without having to go through a competitive procurement process. It will be important to ensure that the right principles are applied to a robust process, with appropriate safeguards, and local areas are supported to develop the strong relationships required to implement this new kind of commissioning. 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.

We understand that amendments to the legislation relating to [the national] tariff support the broad policy direction towards system finances, and we are particularly closely engaged with NHSE/I colleagues and members to help shape how that might operate. We will work with NHSE/I and DHSC to understand the provision to remove NHSI's involvement in requests for local price modifications. Likewise, 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 CMA. Importantly, we are pleased that the DHSC intend to maintain the financial rigour and benchmarking that the tariff offers.

New trusts

We are concerned about the implications of secretary of state having a broad power to create new trusts, particularly given this power will sit alongside a number of other powers aimed offering the potential for central direction. This opens up the potential for political involvement at a local service delivery level, and without sufficient safeguards could destabilise a local health and care economy. Developments such as this, in our view, should be locally determined.

LETBs

Trust leaders support ICSs taking on additional workforce responsibilities that make sense for their local system. The removal of LETBs in statute will be one part of a wider move towards a new operating model for the workforce, and serves to formalise the current, positive direction of travel.

Ensuring accountability and enhancing public confidence proposals:

Merging NHS England, Monitor and the NHS Trust Development Authority and secretary of state powers of direction

In line with NHSE/I's recommendations, the government is proposing formally bringing NHS England and NHS Improvement together as one legal entity.

The newly merged NHS England will remain answerable to the secretary of state and parliament for all aspects of NHS performance, finance and care transformation. The government is also proposing to bring forward a proposal to give the secretary of state "appropriate intervention powers" over the newly formed NHS England. DHSC sees this proposal as maintaining clinical and day-to-day operational independence for the NHS, but reinforcing accountability and agility by allowing the secretary of state to formally direct NHS England. While DHSC acknowledges that most issues should be resolved within systems rather than at national level, there are occasions when national intervention and oversight is necessary, and these powers will ensure ministers are accountable for them.

These powers will not allow the secretary of state to direct local NHS organisations, directly nor will they allow the secretary of state to intervene in individual clinical decisions. They will not undermine NICE process and guidance for treatment and medicines.

The NHS Mandate

The government is proposing to replace the current legislative requirement to have a new mandate each year with a new requirement to always have a mandate in place, and for this mandate to be changed in-year. The document argues that this well help align with strategic developments and external events.

This proposal will remove the duty to set NHS England's capital and revenue resource limits in the mandate itself. Instead, these limits will continue to be set within the annual financial directions that

are routinely published, and which will, in future, also be laid in Parliament. The direction set in the mandate will also continue to be closely aligned to the capital and resource spending limits.

Additional consequential changes will also be made to the current legal provisions on integration (the Better Care Fund) which currently rely on the NHS mandate. These provisions will be recreated as a standalone power so that they will continue to meet the policy intention for the Better care fund even where mandates are not replaced annually.

Each new mandate will continue to be laid in parliament by the secretary of state. NHS mandate requirements will also continue to be underpinned by negative resolution regulations, providing further opportunity for parliament to engage with the content of the mandate. The existing duty for the secretary of state to consult NHS England, Healthwatch England, and any other persons they consider appropriate before setting objectives in a mandate, will also remain in place.

Reconfigurations intervention power

The government is proposing to broaden the scope for potential ministerial intervention in reconfigurations, allowing the secretary of state to intervene at any point of the reconfiguration process. Currently, the secretary of state is only able to intervene in service reconfigurations upon referral from a local authority, usually in difficult or complex cases. Under the new proposal, the secretary of state will be required to seek appropriate advice in advance of their decision, including in relation to value for money, and subsequently publish it in a transparent manner.

Guidance will be issued by DHSC on how this process will work as well as removing the current local authority referral process to avoid creating any conflicts of interest. DHSC expects the Independent Reconfiguration Panel, established in 2003 to be replaced by new arrangements.

It is not anticipated that this power be used frequently but where there are issues that ministers have concluded need to be pressed to a resolution, this will provide a means of doing so.

Arm's Length Bodies (ALB) Transfer of Functions

The government is proposing to create a power in primary legislation for the secretary of state to transfer functions to and from specified ALBs, and to abolish ALBs that 'become redundant'. This power will only be exercisable via a Statutory Instrument, approved by both houses of parliament, following formal consultation and consideration of any recommendations by parliamentary committees. This power aims to allow flexibility to adapt to changes in priorities and avoid complex

workarounds, as experienced between NHSE/I. DHSC states there is no immediate plan to use this power.

Removing Special Health Authorities (SpHAs) Time Limits

Currently, existing legislation sets an automatic expiry date on SpHAs (for example NHS Business Services Authority, NHS Blood and Transplant etc) which requires the government to formally extend their existence every three years. In order to reduce bureaucracy and cut administration costs, the government's proposal will remove the three-year time limit on all SpHAs (but only NHS Counter Fraud Authority is currently impacted).

Workforce Accountability

The DHSC is proposing to create a duty for secretary of state to publish a document, once every five years, and in collaboration with HEE and NHSE/I, which sets out roles and responsibilities for workforce planning and supply at national, regional and local level in England. This document would also cover sections of the workforce that are shared across health and social care.

NHS Providers View

Merger of NHSE and NHSI and proposed powers of intervention

We welcome the closer working of NHSE/I. However, we are concerned about the cumulative impact of the proposed enhanced powers of direction for the secretary of state over the newly merged NHSE. The clinical and operational independence of the NHS – free from political intervention – is an important cornerstone of our health and care system.

Viewed in the round alongside other proposals for the secretary of state to have powers to create new trusts and intervene at any stage in NHS service reconfigurations, these proposals risk an unjustified swing of power towards the centre at the cost of local accountability mechanisms. While we welcome DHSC's reassurance that 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 will consult with trust leaders on these new secretary of state powers, and identify the risks and unintended consequences in these proposals.

In addition, new powers for secretary of state to transfer functions between ALBs and ultimately abolish them, represents a further significant centralisation of power in DHSC. It is encouraging that these powers could only be exercised via SI after formal consultation and approval from both houses

of parliament, but would encourage DHSC to provide safeguards to prevent Henry VIII clauses being used to circumvent due parliamentary process.

While there may be a logic in changing the length of the NHS mandate to respond to wider circumstances in-year, there is also a strong logic in maintaining the link between the strategic asks of the NHS to the annual NHS financial cycle.

We will seek to understand the detailed implications of removing the time limits on special health authorities before commenting further.

Workforce accountabilities

We and other stakeholders have called for further clarity around how workforce accountabilities are shared at national, regional and local level. It is encouraging that secretary of state will need to do so publicly, but we note that the key issue of workforce shortages and future supply to meet demand remains unaddressed in this White Paper.

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

Social Care

ICSs and Adult Social Care

DHSC intends to create a more clearly defined role for social care within the structure of a statutory ICS NHS Board, to give adult social care a greater voice in NHS planning and allocation. ICS legislation will complement and reinvigorate place-based structures for integration between the NHS and social care, including through HWBs, the ICS health and care partnership and the Better Care Fund.

Improve the quality and availability of data across the health and social care sector

DHSC wants to gather data from social care providers (for local authority and privately funded care) to remedy gaps in available data and to better understand capacity and risk in the system. DHSC states that high quality data should be collected to "agreed high standards" and meet the needs of all users. It should be collected once to reduce reporting burdens and used intelligently to support commissioning and delivery of high-quality services.

A new assurance framework for social care

The government is proposing to introduce a new duty for CQC to assess local authorities' delivery of their adult social care duties. Linked to this new duty DHSC also proposes introducing a power for the secretary of state to intervene where, following assessment under the new CQC duty, it is considered that a local authority is failing to meet their duties. Any intervention by the secretary of state would be proportionate to the issues identified and taken as a final step in exceptional circumstances when help and support options have been exhausted.
The government aims to secure these provisions in primary legislation at a high-level, prior to working with government partners and the sector on detailed system design and practice.

Provide a power for the secretary of state to make payments directly to providers

The government proposes to allow the secretary of state to make direct payments to adult social care providers in England. The Bill will not prescribe in what circumstances the power can be used, or how this funding should be provided. Instead, this power will act as a legal foundation for future policy proposals
The type of payment will be determined on a case-by-case basis. However, this power will not be used to amend or replace the existing system of funding adult social care, where funding for state provision is provided via local authorities. It will only be used in exceptional circumstances. Discharge to assess.

The government will put in pace a legal framework for a 'Discharge to Assess' model, whereby NHS Continuing Healthcare (CHC) NHS Funded Nursing Care assessments and Care Act assessments can take place after an individual has been discharged from acute care. This will replace the existing legal requirement for all assessments to take place prior to discharge.
Discharge to assess will not change the thresholds of eligibility for CHC or support through the Care Act or increase financial burdens on local authorities. The system of discharge notices, and associated financial penalties, will also be removed by this legislation.

A standalone power for the Better care fund (BCF)

Currently the allocation of the BCF is tied to the NHS mandate. Given that the process for setting the mandate will be amended, the government proposes to create a standalone legislative power to support the Better Care Fund and separate it from the mandate setting process.

Public Health

Public Health power of direction

The government proposes to create a power for the secretary of state to require NHS England to discharge public health functions delegated by the secretary of state alongside the existing section 7A provisions.

Other public health measures

The government proposes to make changes to legislation to support its ambitions to halve childhood obesity by 2030, to reduce the number of adults living with obesity and to reduce health inequalities. These changes include strengthening labelling requirements and introducing further advertising restrictions to prohibit advertisements for products high in fat, sugar or salt (HFSS) being shown on TV before 9pm via this Bill. Depending on the outcome of a recent consultation, it is the intention of the government to take forward further online advertising restrictions in this legislation.

The government proposes to give the secretary of state the power to directly introduce, vary or terminate water fluoridation schemes.

NHS Providers View

Social care

Social care reform is long overdue. While the White Paper does not address the longstanding issues in the social care system, it does reiterate the government's intention to “bring forward separate proposals on social care reform this year”. We agree that one policy paper or 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.

The proposals state that adult social care will have a greater voice in NHS planning and allocation at the ICS NHS Board, leading to a more clearly defined role for social care within ICSs. However, it remains unclear how the proposals truly address the original ambitions of bringing health and social care closer together at ICS level. While pooled budgets and guidance on joint appointments at place level are welcome, as this is where the majority of service integration will take place, this does not fully address the wider strategic ambition of designing a more integrated health and social care system. We also note that the efficacy of HWBs still varies across the country, and would welcome more detail

on how DHSC, NHSE/I and local government partners will ensure that joining up health and social care remains a key priority.

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.

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. This is better for patients, as more time in a hospital bed can lead to mental and physical deterioration, and better for the system if patients are not waiting for an assessment for long-term care in an acute bed. 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 (I.e. remove CHC) and consider with the community sector whether the new policy can be delivered through guidance.

Public health

The proposal for secretary of state to have powers to direct NHSE 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 (e.g. health improvement) will continue to be commissioned by local authorities, this new power suggests in future they may return to the NHS. Caution must be taken to avoid destabilising changes to public health services, and 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, full and sustainable funding is essential to secure the effectiveness of public health services.

Safety and Quality

Health Service Safety Investigations Body

The Health Service Safety Investigations (HSSI) Bill was introduced in October 2019. The government intends to bring provisions from the HSSI Bill into the Health and Care Bill.

The provisions propose establishing a new independent body, the Health Service Safety Investigations Body (HSSIB) to investigate incidents which have or may have implications for the safety of patients in the NHS. This body will be established as an executive non-departmental public body with powers to investigate the most serious patient safety risks to support system learning. HSSIB will continue the work of the Healthcare Safety Investigations Branch which became operational in April 2017 as part of NHS Improvement.

This proposal will:
- prohibit disclosure of information held by the HSSIB in connection with its investigatory function save in limited circumstances set out in the Bill. The aim is to create a 'safe space'.
- encourage the spread of a culture of learning within the NHS. To this end the HSSIB will provide advice, guidance and training to organisations.

The government plans to extend HSSIB's remit to cover healthcare provided in and by the independent sector. They are also introducing a power to enable the secretary of state for to require HSSIB to carry out certain investigations into particular qualifying incidents or groups of qualifying incidents. A regulation-making power allowing the secretary of state to set out additional circumstances when the prohibition on disclosure (safe space) does not apply will also be included.

Professional regulation

Proposals for professional regulation form part of a wider programme to create a more flexible and proportionate professional regulatory framework that is better able to protect patients and the public. The secretary of state will be enabled to make further reforms to ensure the professional regulation system delivers public protection in a modern and effective way.

The proposal includes, but is not limited to, the power to remove a profession from regulation, abolish an individual health and care professional regulator, and remove restrictions regarding the power to delegate functions through legislation.

It also includes the power to extend the scope of section 60 to include senior NHS managers and leaders, to enable them to be regulated in future. While there are no plans at this stage to statutorily regulate senior NHS managers and leaders, extending the scope of professions who can be regulated using the powers in Section 60 of the Health Act 1999 to include these groups would enable this to be brought forward in the future, if further measures are needed following those currently being

proposed by NHS England/Improvement to address the concerns raised in the 2019 Kark Review. However, the Kark review stopped short of recommending full statutory regulation and NHSI is currently considering how best to achieve this through non-statutory means.

Medical examiners

This proposal would see existing legislation amended to establish a statutory medical examiner system within the NHS for the purpose of scrutinising all deaths which do not involve a coroner.

This proposal will amend the Coroners and Justice Act 2009 to allow for NHS bodies, rather than local authorities, to appoint medical examiners.

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

The White Paper includes proposals for the MHRA to develop and maintain publicly funded and operated medicine registries where there is a clear patient safety or other important clinical interest. The aim of this proposal is to ensure that patients and prescribers, as well as regulators and the NHS, are provided with the evidence they need to make informed decisions about the medicines they use, as current registries (created by authorised companies) have not always delivered the required evidence in reasonable timeframes. This proposal will also enable registries to identify and investigate potential non-compliance, so that additional action can be taken by regulators.

Hospital food standards

The Independent Review of NHS Hospital Food was published on the 26th October 2020. It recommended that NHS food and drink standards for patients, staff and visitors be put on a statutory footing. This is supported by the government and it is proposed to grant the secretary of state for powers to adopt secondary legislation that will implement the national standards for food across the NHS.

Reciprocal healthcare agreements with Rest of World countries

Proposed legislation will enable the government to implement more comprehensive reciprocal healthcare agreements with Rest of World countries subject to negotiations. Under the current legislation, the UK is limited to implementing such arrangements with the EU, EEA, EFTA blocs or their Member States.

The proposed legislation will introduce a reimbursement mechanism and data exchange.

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

NHS Providers View

We understand the motivation for DHSC to add a wide range of legislative measures to the Health and Care Bill, given this may be the only legislative window for the NHS in parliament. However, this makes for a wide-ranging Bill, rather than a cohesive, targeted set of legislative reform.

Professional regulation

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.

HSSIB

NHS Providers welcomes the proposals to establish 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. We have strongly supported the creation of HSSIB since it was announced, as its investigations fill an important gap in how the NHS learns from patient safety incidents, and we contributed to the Joint Committee's pre-legislative scrutiny work in support of HSSIB. However, the proposal for HSSIB to be established as an executive non-departmental public body, which means it will be accountable to parliament through its sponsoring DHSC ministers, 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.

Medical examiners

We welcome confirmation that the non-statutory phase of the medical examiner programme will continue for this coming year, however clarity will be needed on whether current arrangements up to March 2021 regarding reimbursement for the cost of medical examiner offices hosted at acute trusts will continue.

We welcome DHSC's commitment to exploring ways to enhance the role of 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.

NHS Providers press statement

Commenting on the release of today's 'White Paper' with legislative proposals for a Health and Care Bill, the chief executive of NHS Providers, Chris Hopson, said:

"There is widespread agreement across the NHS on many of the proposals in this paper thanks to the work done by NHS England and NHS Improvement and the Health and Social Care Committee to draw up a set of agreed legislative proposals in 2019, a process to which NHS Providers contributed extensively. We are pleased to see that this work forms the bedrock of what is now being proposed.

"These proposals provide an important opportunity to speed up the move to integrate health and care at a local level, replace competition with collaboration and reform an unnecessarily rigid NHS approach to procurement.

"There is a lot of detail to get right in what is now a wide ranging bill. 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 arms length bodies and intervene in local reconfigurations.

"It is also vital that the proposed new statutory powers for ICSs avoid overlap and duplication with the statutory powers of trusts and Foundation Trusts which the Government rightly says it will maintain as the key delivery mechanism for ambulance, community, hospital and mental health care services.

"We will also want to discuss how quickly these changes can be implemented given the operational pressures the NHS is currently facing.

"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".

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