

Briefing

# The health and care bill

The government has published a bill setting out how it intends to reform the delivery of health services and promote integration between health and care in England.

This briefing provides a summary of the legislative proposals and sets out our view on the detail and what lies ahead.

# Key points

- The government has published a bill setting out how it intends to reform the delivery of health services and promote integration between health and care in England. This is the first major piece of primary legislation on health and care in England since the Health and Social Care Act 2012.
- Our members have broadly welcomed the reforms, many of which were set out in a [white paper](#) in the spring. There is clear consensus across our membership that the future of health and care must be based on collaboration and partnership working at a local level. These reforms will provide the necessary updates to legislation to make that happen.
- The bill, which is structured in six parts, focuses largely on the detail on how a new health and care system based on integration rather than competition will be structured. This includes specifications on how integrated care systems (ICSs) are to be set up and the distinct statutory functions for the integrated care board (ICB) and integrated care partnership.
- It does include some controversial elements. Despite public opposition from us and others, the government is proceeding with measures to increase powers for the Secretary of State over various aspects of the NHS's operation, notably including local service reconfigurations. We continue to have concerns over the implications of such powers and will be pressing for robust checks and balances to govern them.
- While the bill largely follows the integrated practices that are already happening on the ground across England, the reforms will necessitate some changes to the way in which NHS organisations operate. For providers, for instance, foundation trusts will be subject to new capital expenditure limits and all trusts and foundation trusts will have a new duty to deliver against the 'triple aim' of improving a) health and wellbeing, (b) the quality of services, and (c) efficiency and sustainable use of resources
- It is important to note that health and care reforms cannot be considered in isolation and there are many fundamental factors that will be crucial to the future success of ICSs that are absent from this bill. Notably, for instance, we still await a robust long-term settlement for social care and a long-term plan for filling workforce shortages across health and care, backed by funding.

- An issue that threatens the ability of statutory ICSs to operate legally and safely by April 2022 is boundaries. Many systems have faced uncertainty on this, amid calls from some quarters for there to be co-terminosity between the boundaries ICSs and upper tier local authorities. Again, while not specifically mentioned in the Bill, this issue jeopardises the progress of affected ICSs and must be resolved as soon as possible.
- Before the bill reaches committee stage (expected in September), we will produce bespoke analysis for members via our networks, conduct a deep-dive analysis and work closely with health leaders across our membership to finesse our policy positions and proposed amendments. We will continue to seek to influence the content of the legislation at all levels and with external partners, where appropriate, to ensure that the forthcoming reforms are effective, proportionate and permissive.

# Priority issues for members: What the bill says

The table below summarises the key issues we have focused on behalf of members in our political and media engagement leading up to the publication of the legislation, as well as what the bill says on each issue. This engagement has included giving evidence to the Health and Social Care Committee, publishing a [report](#) on the reforms set out in the white paper and working directly with the Department of Health and Social Care (DHSC) as it developed the content of the reforms.

Beyond the areas below, our networks have also influenced on more specific issues relating to their members.

What we said	Detail of the bill
<p><b>Increased powers for the Secretary of State</b></p> <p>We have raised concerns about new powers for the Secretary of State, notably on the issue of intervention in local service reconfigurations.</p> <p>We have questioned the need for such powers but argued that, should the government proceed, there should be robust checks and balances in place over them. These should include clear processes for local resolution in the first instance; criteria indicating when and how Secretary of State intervention is needed; a requirement for the Secretary of State to consider local clinical advice and any other advice offered by the affected ICS on a service reconfiguration decision, all of which should be in the public domain.</p>	<p>The government is proceeding with increasing powers for the Secretary of State over local service reconfigurations.</p> <p>Schedule 6 of the bill confers intervention powers on the Secretary of State in relation to the reconfiguration of NHS services, including deciding whether a reconfiguration proposal should, or should not, proceed, or should proceed in a modified form. The wording of the bill also seems to indicate that the Secretary of State can introduce or catalyse service reconfiguration decisions, even before they have been considered locally or by NHS England, and this is of concern.</p> <p>The bill refers to guidance that will support such powers and states that the Secretary of State must publish any decision made about a reconfiguration and notify the</p>

NHS commissioning body.

We await further details of this guidance but remain concerned about the limited checks and balances that appear to be in place over Secretary of State powers in relation to local service reconfigurations.

We have already heard from members that the 'call-in' power of the Secretary of State on reconfigurations may create a reluctance to move ahead with system service changes if there is likely to be a centralised decision made upon them.

### **Governance and accountability**

We have called for the legislation to clarify what the statutory function of the two component bodies of an ICS is and for legislation to avoid indicating that one is less important than the other.

The bill is broadly clear that the integrated care board (ICB) will be responsible for commissioning certain health services and have a range of legal duties, notably including to promote the NHS Constitution, reduce inequalities, maintain patient choice and promote integration.

The ICB and each local authority is responsible for forming an integrated care partnership (ICP), which must create an integrated care strategy and involve people who live in the partnership's area. There are, however, important statutory roles for health and wellbeing boards (HWBs), which must (for instance) be involved in the preparation of ICB strategy. This raises a conundrum over what the relationship, and difference, will be between HWBs and ICPs. There are also unanswered questions over what happens in certain systems where different HWBs disagree on key issues relating to ICS strategy.

How the two component ICS bodies work will largely depend on culture and relationships. There is also a raft of supporting guidance still expected over the coming months, the detail of which will have significant implications for ICS dynamics. We will continue to support NHS England and the government on ensuring such guidance is permissive and proportionate.

### **Duty to collaborate**

We have welcomed the notion of a duty to collaborate but have stated it should be formulated around a duty to collaborate to reduce health inequalities, given the broad support for this goal.

The duty is formulated as a less specific 'duty to cooperate'.

The bill introduces a new power that allows the Secretary of State to issue guidance on cooperation between NHS bodies, and between NHS bodies and local authorities, giving organisations greater clarity about what the duties to cooperate mean in practice. We will seek to input into this guidance to ensure that the duty works effectively for NHS organisations.

### **Pace and timescales**

We have repeatedly stated our concerns around the short timeline outlined for the bill, which will see ICSs becoming statutory bodies in April 2022.

We welcome that the government has brought the bill forward before the summer recess (see below).

It remains crucial that this is achieved by 22 July when parliament rises for summer recess to give affected NHS staff assurance that it can be enacted by April 2022.

## **Workforce planning**

We published a joint statement with the Academy of Medical Royal Colleges, the British Medical Association, NHS Providers, the Royal College of Nursing and UNISON calling for issues contained in the NHS People Plan to be addressed, including improving staff wellbeing, arrangements for flexible working, increasing workforce supply, transformation and leadership.

We are disappointed that the bill is largely silent on workforce planning, which in our view is a missed opportunity to address chronic staffing shortages across the health and social care sector.

There is a duty on the Secretary of State to publish, at least once every five years, a report describing the system in place for assessing and meeting the workforce needs of the health service in England. However, this is insufficient and far too infrequent.

# NHS Confederation viewpoint

Health leaders broadly welcome this bill. We believe the reforms brought in under the Health and Social Care Act 2012 require changes to further facilitate system collaboration. There is clear consensus across our membership that the future of health and care must be based on collaboration and partnership working at a local level, and these reforms will provide the necessary updates to legislation to make that happen. In many ways, the legislation is catching up with what is happening on the ground.

Our members are relieved that the bill has been brought forward before the summer recess. As we have publicly drawn attention to in recent weeks, the timetable for ensuring that statutory ICSs are able to take on statutory responsibilities legally, effectively and most importantly, safely by April 2022, is incredibly tight. We are grateful that the government has listened to the concerns of NHS leaders on this issue, pressed ahead with the bill and given ICSs increased certainty for the coming 18 months.

That said, there are some areas of the bill where we have concerns. As set out in the table above, an issue we have been clear in opposing has been increased powers for the Secretary of State – notably in areas such as local service reconfigurations. Despite our opposition, the government is proceeding with introducing such powers and we are concerned about the implications that this will have for ICS' autonomy and the key role of local overview and scrutiny. We will continue to press for robust checks and balances to ensure that such powers are proportionate and limited.

These reforms cannot be considered in isolation and their success will rely upon several factors not contained within the bill. The future of social care, for example, remains uncertain. We have been clear that ICSs must not be considered as NHS bodies, but as partnerships between the NHS, local government and the voluntary, social enterprise and independent sectors that bring together health and care.

While the reforms in the bill cover financial arrangements for the provision of health services, we are concerned that local authorities will continue to feel like junior partners in ICSs until they are given a sustainable, long-term financial settlement for social care. Similarly, while we welcome the permissiveness of much of the bill, there are concerns that in its current form it risks being a step backwards for mental health as there is no commitment to parity of esteem.

On workforce, we are clear that there needs to be a comprehensive long-term plan to address workforce shortages across health and care, backed by funding. We are disappointed that the bill is silent on this topic.

Another issue not contained within the bill is ICS boundaries. Many systems still face uncertainty over their boundaries given the stated position in the recent white paper that ICS boundaries should 'frequently' be co-terminous, and amid calls from some quarters for there to consistency with local authority boundaries. This issue threatens the progress of affected ICSs and must be resolved as soon as possible.

Looking ahead, there is a significant degree of guidance that will support the implementation of measures outlined in the bill. We have been clear that while the bill is, for the most part, flexible and permissive, we must ensure that health and care organisations are not restricted by overly prescriptive and rigid guidance. We look forward to supporting NHS England and NHS Improvement and the government to get this guidance right over the coming weeks and months.

Finally, the success of integrated working under a new statutory framework will depend much more on the relationships and culture between organisations at local level than it will on the details of this bill. We will therefore continue to promote positive case studies of collaboration at local level to help promote best practice and effective partnership working. Further to this briefing, we will set out more detailed positions on specific aspects of the bill in due course.

# The bill at a glance

The bill is structured in six parts:

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

The key points of each of these six parts are summarised below.

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

## **NHS England**

- NHS England and NHS Improvement are legally merged under the name NHS England (NHSE).
- The Secretary of State is given the power to revise the NHS Mandate.
- Powers are introduced for NHSE functions (notably including commissioning functions) to be exercised by integrated care boards.
- The government may direct NHSE (and subsequently NHS England may direct integrated care boards) to use particular allocations of funding for the purposes of service integration.

## **Integrated care boards**

- A duty is placed on NHSE to establish integrated care boards (ICBs) covering England. Details of the constitutions of ICBs (which must be published) are set out under Schedule 1b and clinical commissioning groups (CCGs) must propose the first constitution of the ICB in its area.
- CCGs are to be legally abolished and provisions are made for the transfer of CCG resources to ICBs and NHSE.
- Measures are set out to ensure ICBs mitigate against conflicts of interest, including a requirement for registers of interest to be maintained for board members and employers.
- Details are provided on the people for whom ICBs have responsibility.

## **Integrated care boards: functions**

- A list is provided of the services that ICBs will be responsible for commissioning, notably including ambulance and nursing services, and dental services other than primary dental services. Schedule 3 confers functions on ICBs in relation to primary care services and contains other amendments relating to primary care services.
- ICBs will have a range of legal duties, notably including to promote the NHS Constitution, reduce inequalities, maintain patient choice and promote integration.

- ICBs must ensure that there is public involvement in the planning of commissioning arrangements and operational commissioning decisions.
- Regulations may provide for any prescribed functions of an ICB to be exercised jointly with a local health board.
- ICBs will have certain powers to raise additional income and make grants, for example to partner trusts.

### **Forward planning and reports**

- ICBs must prepare and publish a plan setting out how they will exercise their functions in the coming five years. These plans must set out how the ICB plans to discharge its duties and the steps it will take to implement any joint local health and wellbeing strategy.
- Each relevant health and wellbeing board and any people for whom the integrated care board has core responsibility should be consulted in the preparation of this plan.
- Before the start of each financial year, ICBs and their partner NHS trusts and NHS foundation trusts must prepare a plan setting out their planned capital resource use.
- If the ICS and partner NHS trusts/foundation trusts revise either of these plans, they must publish this and share a copy with the ICP, each relevant health and wellbeing board and NHSE.
- ICBs must, in each financial year, prepare an annual report on how they have discharged their functions in the previous financial year.
- NHSE must conduct a performance assessment of each integrated care board in respect of each financial year, consulting each relevant health and wellbeing board.
- If the ICB is failing or is likely to fail to discharge its functions, NHSE may terminate the appointment of the ICB's chief executive and direct the chair of the board on their replacement. It may also direct the chief executive of another ICB to perform any of those functions.

### **Integrated care partnerships**

- This section requires ICBs and each local authority to establish an integrated care partnership (ICP). Each ICP must then create an integrated care strategy, considering the NHS Mandate, Secretary of State guidance and involve people who live in the partnership's area.

- The responsible local authority and each of its partnership boards must prepare a 'joint local health and wellbeing strategy' setting out how they will meet the needs of the local area.
- Schedule 4 sets out that ICPs are to consist of (a) one member appointed by the integrated care board, (b) one member appointed by each of the responsible local authorities, and (c) any members appointed by the integrated care partnership.

### **NHS England's financial responsibilities**

- NHSE must ensure that total spending for both capital and revenue do not exceed the limits set by the Secretary of State.

### **Financial responsibilities of integrated care boards and their partners**

- NHSE may impose financial requirements on ICBs. ICBs must not spend more than they have been allocated each year for both revenue and capital.
- The Secretary of State is given powers to specify what counts as revenue and what counts as capital spending for an ICB.

### **Merger of NHS bodies**

- Monitor is abolished and merges function with the new NHS England.
- NHS England must minimise or manage any conflicts that arise between their regulatory functions.
- NHS England, replacing previous Monitor responsibilities, must carry out an assessment of the likely impact of modifications to providers' licenses.
- The NHS Trust Development Authority is abolished.
- Various transitional arrangements are set out between the abolished bodies and NHS England for tax, property and legal purposes.

### **Secretary of State's functions**

- The Secretary of State must, at least once every five years, publish a report describing the system in place for assessing and meeting the workforce needs of the health service in England.
- The Secretary of State may arrange for any of the public health functions of the Secretary of State to be exercised by one or more relevant bodies (including NHSE, ICBs and local authorities).
- The Secretary of State may direct NHSE or another public body to exercise investigation functions.

- In regards to power of direction over NHSE, the Secretary of State may give NHS England directions as to the exercise of any of its functions. When doing so, however, the Secretary of State must state that they consider this to be in the public interest. Appointments made by NHS England (including within trusts and foundation trusts) are excluded from this.
- Schedule 6 of the bill confers intervention powers on the Secretary of State in relation to the reconfiguration of NHS services, including deciding whether a reconfiguration proposal should, or should not, proceed, or should proceed in a modified form.
- The bill refers to guidance that will support such powers and states that the Secretary of State must publish any decision made about a reconfiguration and notify the NHS commissioning body. Schedule 6 confers intervention powers on the Secretary of State in relation to the reconfiguration of NHS services.

### **NHS trusts**

- All NHS trusts and foundation trusts will have a 'duty to have regard to wider effect of decisions' relating to the 'triple aim' of (a) health and wellbeing, (b) the quality of services, and (c) efficiency and sustainable use of resources, as detailed in NHS England guidance.
- NHS England may give directions to NHS trusts about the exercise of any of their functions.
- NHS trusts must provide annual accounts to NHS England, rather than the Secretary of State.
- NHS England may make recommendations to NHS trusts about mergers.
- Applications to become foundation trusts no longer need support of the Secretary of State, but will require their sign off.
- NHS trust chairs are to be appointed by NHS England, rather than to the Secretary of State.
- NHS England may set financial objectives for NHS trusts.

### **NHS foundation trusts**

- NHS England can impose capital limits on NHS foundation trusts' expenditure for specific time periods, following a legal duty to consult the trusts.
- NHS England has a legal duty to publish guidance about the exercise of capital spending limits for foundation trusts.

- Specific requirements relating to the publication of NHS foundation trusts' accounts, reports and forward plans are loosened, for instance, no longer providing detailed information about income raised from activities not related to service provision, or requiring forward plans approved by FT directors.
- NHS foundation trusts may enter into arrangements for carrying out functions jointly.
- Applications for foundation trusts to merge no longer need support from the Secretary of State.

### **Joint working and delegation of functions**

- NHS England, integrated boards, NHS trusts and NHS foundation trusts can exercise functions jointly with local authorities and combined authorities. Payment terms must be specified and functions cannot be sub-delegated.
- Joint functions can be exercised by (a) a joint committee or (b) by a specific organisation or joint committee through a pooled fund.

### **Collaborative working**

- The Secretary of State and NHS England's respective duties to promote autonomy are abolished, removing potential conflict with duties for system partners to cooperate and consider the interests of the wider health system.
- Joint appointments can be made across NHS commissioners, providers and/or local authorities, subject to NHS England guidance.
- The Secretary of State may publish guidance on the discharge of the duty of NHS bodies and local authorities to cooperate to promote health and welfare.
- NHS England must have regard to the 'triple aim' when licensing healthcare providers.

### **NHS payment scheme**

- The national tariff is renamed the NHS payment scheme.
- NHS England must publish rules for pricing healthcare services which must provide for a fair level of payment for providers of those services.
- NHS England must carry out an impact assessment (or rationale for not conducting an assessment) before publishing the NHS payment scheme. NHS England must consult relevant integrated care boards, providers and other relevant bodies on the payment scheme. It must also consider the impact on integrated care boards and relevant providers, and whether they would be disproportionately affected.

## **Patient choice and provider selection**

- NHS England must impose 'standing rules' to protect patient choice and may investigate integrated care boards if they fail to comply. NHS England must publish guidance on such investigations.
- The National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 (S.I. 2013/500) are revoked.
- The Secretary of State must issue procurement regulations for delivery of NHS services' mixed procurements (such as with social care services), which ensure transparency, fairness and manage conflict of interest. NHS England may publish guidance that will set out how relevant authorities can comply with the requirements.

## **Competition**

- The Competition and Markets Authority (CMA) will no longer regulate mergers between NHS organisations. Mergers between NHS mergers and non-NHS bodies, however, remain in scope. NHS England has a duty to assist the CMA with investigations.
- NHS England, as the national regulator, will continue to review proposed transactions, including mergers or acquisitions, to ensure there are clear patient benefits.
- All NHS foundation trusts and most other providers of NHS services (but not NHS trusts) must hold a provider licence.

## **Miscellaneous**

- NHS trusts must keep proper accounts and records, as specified by the Secretary of State, which can be examined by the Comptroller and Auditor General.
- NHS trusts must share annual accounts with NHS England.
- The Secretary of State's powers to make a property transfer schemes or a staff transfer schemes (in connection with the establishment or abolition of an NHS body) are repealed.
- The committees of Health Education England called local education and training boards (LTEBs) are abolished.
- NHS organisations' ability to charge local authorities for failing to arrange a social care needs assessment is abolished.

## Part 2: Health and adult social care: information

- Requirements for information standards around the provision of health and social care providers and circumstances in which requests can be issued and the role of the Information Centre are set out under this section, including a new chapter on information about adult social care (section 277A).
- Chapter 4 sets out enforcement provisions for failures to comply with an information standard, which under the Act can result in financial penalties.

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

- The Secretary of State can transfer a function of one 'relevant body' to another for the purpose of improving the exercise of a public function.
- Relevant bodies include NHS England, Health Education England, the Health and Social Care Information Centre, the Health Research Authority, the Human Fertilisation and Embryology Authority and the Human Tissue Authority.
- The Secretary of State is unable to transfer a function of NHS England if this would make NHS England redundant.
- The Secretary of State can confer onto or abolish functions of a body, change the purpose of the body's exercise of a function or the conditions under which the body exercises a function.
- These powers extend to the bodies' name, appointment of the bodies' chair, members and staff, its governing procedures and arrangements and its reports and accounts. There are provisions for modifying the funding arrangements of a body contained in sections 87 and 88.
- This power extends to England and Wales, Scotland and Northern Ireland.

## Part 4: The Health Service Safety Investigations Body

- The Health Service Safety Investigations Body (HSSIB) is to be established and will be mandated to investigate incidents where the provision of healthcare services has or may have implications for the safety of patients. It will address those risks by facilitating the improvement of systems and practices in the provision of these services.
- The Secretary of State may direct the HSSIB to carry out an investigation of a particular safety incident or incidents.
- The HSSIB will be responsible for determining and publishing the criteria it will use to determine which incidents it investigates, and its principles and processes for carrying out investigations, ensuring that patients and their families are involved.
- When the HSSIB completes an investigation, it must publish a report on the outcome of the investigation and may publish interim reports on any matter relating to the investigation. The report will not be admissible in civil or criminal proceedings or appeals, or proceedings or appeals before an employment tribunal or regulatory body.
- If an investigator considers it necessary for the purposes of an investigation, they can enter and inspect premises, inspect and take copies of or seize documents, and inspect and seize equipment.
- By notice an investigator can require individuals to provide information in person, by providing specified information or documents, equipment or items, by a specified date. The specifications for notices are provided under section 103.
- It will be a criminal offence if the person intentionally obstructs the investigation or fails to comply with a notice without reasonable excuse.
- Where the HSSIB is carrying out an investigation and another organisation such as NHSE, the Care Quality Commission or an ICS board is carrying out an investigation into the same or a related incident, they must cooperate with each other regarding practical arrangements for coordinating those investigations. It must comply with any request by an NHS body (including an ICS) or NHSE to provide assistance in carrying out investigations of incidents.

## Part 5: Miscellaneous

### **International healthcare**

- The Secretary of State may make provision for the purpose of giving effect to a healthcare agreement (including provision about payments), for example by conferring functions on a public authority.
- The Secretary of State may make provision authorising the Secretary of State to make a payment (otherwise than under a healthcare agreement) in respect of healthcare provided in a relevant country or territory, but only where the Secretary of State considers that exceptional circumstances justify the payment.

### **Social care: regulation and financial assistance**

- The CQC must conduct reviews of the exercise of regulated care functions by local authorities (adult social care functions under Part 1 of the Care Act 2014), assess the performance of those authorities following reviews and publish a report of its assessment.
- The Secretary of State must set (and if necessary revise) objectives and priorities for the Commission for assessment of local authorities.
- The CQC must determine (and if necessary revise) indicators of quality for the assessment of local authorities, subject to the approval of the Secretary of State. The Secretary of State may direct the CQC to revise these indicators.
- The CQC must put out a statement (approved by the Secretary of State) on the frequency of such reviews and the methods it will use to assess and evaluate the performance of local authorities.
- The Secretary of State may give financial assistance to bodies which provide social care services or services that are connected to social care services in England. This will enable the Secretary of State to make payments to private providers of social care services.

### **Professional regulation**

- A profession currently regulated can be removed from statutory regulation when the profession no longer requires regulation for the purpose of the protection of the public.
- An order may abolish an individual health and care professional regulatory body, where the profession(s) it regulates continues to be regulated by another regulatory body or where the profession(s) has been removed from regulation.

- Health and care regulatory bodies will be able to delegate certain functions to another regulatory body, including the keeping of a register; determining standards of education and training for admission to practice and providing advice about standards of conduct and performance; and carrying out the fitness to practise function.
- These powers all extend to the currently unenacted provisions concerning social care workers in England.

### **Medical examiners**

- NHS bodies will be able to appoint medical examiners. The Secretary of State will ensure that enough medical examiners are appointed in the healthcare system in England, that enough funds and resources are made available to medical examiners to enable them to carry out their functions of scrutiny to identify and deter poor practice, and to ensure that their performance is monitored.
- The Secretary of State will be able to give a direction to an English NHS body (including an ICS) in order to: require the body to appoint one or more medical examiners; set out the funds or resources that should be made available to such employed medical examiner; set out the means and methods that may be employed to monitor performance of medical examiners. The NHS body will not have any role in relation to the professional judgement of medical examiners.

### **Food and drink**

- The bill contains provisions restricting advertising of less healthy food and drink which come into force on 1 January 2023.
- The Secretary of State will be able to impose requirements in relation to food or drink provided or made available to any person on hospital premises in England.
- The Secretary of State, as well as ministers in Scotland and Wales, will be able to amend requirements on food information and labelling contained in EU legislation outlining hospital food standards and for information for consumers.

### **Fluoridation of water supplies**

- The power to initiate new water fluoridation schemes or make variations or to terminate existing schemes in England will transfer from local authorities to the Secretary of State.

## Part 6: General

- The Secretary of State will have a power to amend, repeal, revoke or otherwise modify any provision within this bill or any provision made by or under primary legislation passed or made either before this Act is passed or later in the same parliamentary session.
- Regulations made under the following powers in the Act must be subject to the affirmative parliamentary procedure (that is, approved by both Houses): Clause 14 (4) which allows the Secretary of State to change the definition of the people for whom integrated care boards are responsible; Clause 87 and 88 regarding the power to transfer functions between arm's-length bodies; Clause 107 regarding HSSIB's prohibition on disclosure; and Clause 130 if any regulations are laid using this power to amend primary legislation.

## Next steps

The health and care bill is on course to pass into law by April 2022. This will be a huge relief to our members – in particular ICS leaders, who now have further clarity on their statutory accountabilities. Timelines are, however, still very tight and there much work to be done to finalise key elements of the bill that will impact our members across the health and social care system.

Before the bill reaches committee stage (expected in September), we will produce bespoke analysis for members via our networks, conduct a deep-dive analysis and work closely with health leaders across our membership to finesse our policy positions and proposed amendments. We will continue to seek to influence the content of the legislation at all levels and with external partners, where appropriate, to ensure that the forthcoming reforms are effective, proportionate and permissive. Given the complexity of our health and social care system, its diversity and culture, there is only so much that can be drafted in legislation. We will continue to work with the Department of Health and Social Care and NHS England and NHS Improvement as they produce further guidance and support to facilitate the changes envisaged by the bill.

As mentioned, we are clear that reforms to these health and care must be accompanied by other factors to be successful. In particular, we will continue to call for the government to publish much-anticipated social care reforms that is backed by a robust, long-term funding settlement.

### Contact us

To find out more about the issues raised in this briefing, please [email William Pett](#), our senior policy adviser.

The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.

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