

## NHS Confederation

### Public Bill Committee: Written Evidence Submission

#### *Health & Care Bill 2021*

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#### 1. Introduction and contact

- [The NHS Confederation](#) is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland.
- We are grateful to the Committee for the opportunity to provide evidence. This evidence submission has been informed by engaging closely with our members across health and care.
- Representatives from the NHS Confederation will be giving oral evidence to the Committee in early September and would be happy to answer any questions on the points made in this submission.
- Should the Committee have any queries or require any further information on this written evidence, please contact William Pett ([William.pett@nhsconfed.org](mailto:William.pett@nhsconfed.org)) or alternatively Edward Jones ([Edward.jones@nhsconfed.org](mailto:Edward.jones@nhsconfed.org)).

#### 2. Executive Summary

Our members are united upon two key principles relating to the Health and Care Bill.

##### **2.1 There is a clear consensus across the NHS in support of moves towards integration**

The NHS Confederation and our members broadly welcome and support the intention of the Health & Care Bill to help integrate services and put integrated care systems (ICSs) on a statutory footing. The Bill is largely based on recommendations from NHS England and Improvement (NHSE), as well as local health and care leaders, to remove legislative barriers to the local integration of care services, which is already underway. This in turn will enable better and more efficient care for patients. NHS leaders are broadly in agreement that the Bill does not represent any move towards “privatisation” of the NHS.

##### **2.2 NHS leaders want as much flexibility as possible**

The proposed legislation should be an enabler of integration and local flexibility, rather than an overly prescriptive set of centralised rules. We therefore support the permissive approach taken in the Bill and call on parliamentarians to resist amendments which would create excessive prescription in law.

Building on these two principles, we urge the Committee to consider the following three asks:

### **2.3 Checks and balances are needed on increased SoS powers on service reconfigurations**

The Health & Care Bill introduces significant and largely unchecked new powers for the Secretary of State (SoS) to intervene at any stage of a local service reconfiguration decision (such as a change in location or the type of treatment provided by an NHS organisation), with no minimum set of information requirements on which to base such a decision.

We continue to argue for clauses introducing these powers to be removed. If they are to remain, however, then there must be greater clarity over when and how they are used. This should help to avoid the confusion that surrounded the recent example of Lancashire Teaching Hospitals Foundation Trust, where the former SoS put on hold a planned consultation on the potential downgrading of the A&E department at Chorley Hospital, with very little information being made public to justify the intervention.

**We therefore propose amendments to ensure that the integrated care board's (ICB's) clinical case for change is considered by the SoS when intervening in local service configurations and that such evidence is made publicly available. We also propose measures to ensure that the SoS consults with relevant Health Overview & Scrutiny Committees and sets out how interventions in decisions are in the public interest.**

These proposed amendments are also supported by the Local Government Association, the British Medical Association, National Voices and the Centre for Governance & Scrutiny.

### **2.4 Integrated care board (ICB) composition should remain permissive**

There will likely be many proposed amendments from across the health and care sector to legally mandate further ICB roles. The NHS Confederation urges the Public Bill Committee to resist supporting such amendments as they may unduly restrict local leaders' ability to have flexibility in future. Our members are clear that the success of ICSs will rely on managing local circumstances and relationships and this requires the ability to exercise judgement. Rather than mandating ICB positions through legislation, we believe that such positions can be ensured through supporting guidance where there is a good reason for doing so.

We also urge the Committee to resist amendments that would mandate that only public sector and "social purpose" organisations can sit on ICBs.

### **2.5 Regulation of ICSs must be lean, light and agile**

The role of the Care Quality Commission (CQC) over ICSs is still to be confirmed. All regulatory frameworks must recognise the significant variation in ICSs in terms of their size, partnerships and population health challenges. Simplistic measures such as 'Ofsted-style ratings' will not acknowledge the complexities that create each unique integrated system. Rather than a heavy-handed external regulatory or special measures approach, local partners will need support to develop their own long-term solutions to the challenges they face together.

### 3. The Health & Care Bill: Top priorities for NHS leaders

#### 3.1 Checks and balances are needed on increased SoS powers on service reconfigurations

##### **The issue:**

Clause 38 introduces significant and largely unchecked new powers for the SoS to intervene at any stage of a local service reconfiguration decision. The SoS may also direct an NHS commissioning body to consider a reconfiguration of NHS services, though it remains unclear what this would mean in practice.

##### **What NHS leaders think:**

There is consensus across our membership that the proposed powers, as currently worded, are of real concern. ICS leaders are worried that difficult decisions about services, taken for understandable reasons relating to quality, safety and/or finances (all being statutory duties of the ICB), will be upended for political reasons, as in the Chorley Hospital example outlined earlier. The NHS is already one of the most centralised health systems in the world and our members are clear that if these reforms are to work then we must resist further centralisation of power in Whitehall.

We are clear that there needs to be public transparency on the decisions that are being made and what evidence base has been considered to make them. This must include a requirement for the SoS to have regard to, and publish, the clinical case offered by the ICB in relation to any decision.

While outside the scope of the NHS itself, there is also concern about SoS powers allowing local democratic accountability (and specifically the role of Health Overview & Scrutiny Committees) to be bypassed. As a principle, we believe that there should be national intervention in service reconfiguration decisions only when resolution cannot be found locally.

##### **Action / amendment required:**

The NHS Confederation has argued for the new SoS powers on service reconfigurations to be reconsidered in their entirety and ideally removed. However, if they are to go ahead then we propose the following amendments (in red and italics) to the Health & Care Bill, under Schedule 6.

These amendments have been agreed with, and are supported by, the Local Government Association (representing local authorities), National Voices (representing patients, service users, carers and voluntary organisations), the British Medical Association (representing clinicians in general practice) and the Centre for Governance & Scrutiny (a national centre of expertise on governance).

## SCHEDULE 6 INTERVENTION POWERS OVER THE RECONFIGURATION OF NHS SERVICES

- 1 In this Schedule –
- “NHS commissioning body” means NHS England or an integrated care board;  
“NHS services” means services provided as part of the health service in England; “NHS trust” means an NHS trust established under section 25;  
*“Relevant Health Overview & Scrutiny Committee means –*  
*(a) in relation to an area that coincides with the area of a Health Overview & Scrutiny Committee;*  
*(b) in relation to an area that may be the whole or part of the area of more than one Health Overview & Scrutiny Committee.*
- “reconfiguration of NHS services” means a change in the arrangements made by an NHS commissioning body for the provision of NHS services where that change has an impact on—
- (a) the manner in which a service is delivered to individuals (at the point when the service is received by users), or
  - (b) the range of health services available to individuals

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### ***Power to call-in proposal for reconfiguration***

- 4 (1) The Secretary of State may give an NHS commissioning body a direction calling in any proposal by the body for the reconfiguration of NHS services.
- (2) Where a direction is given under sub-paragraph (1), the Secretary of State—
- (a) may take any decision in relation to the proposal that could have been taken by the NHS commissioning body,
  - (b) must notify the NHS commissioning body once the Secretary of State has finished considering the proposal, *and*
  - (c) must consult with relevant Health Overview & Scrutiny Committees*

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- (4) The Secretary of State must—
- (a) publish any decision under sub-paragraph (2)(a),
  - (b) have regard to, and publish, clinical advice of the Integrated Care Board’s Medical Director in relation to any decision under sub-paragraph (2)(a),*

*(c) publish a statement demonstrating that any decision made under sub-paragraph (2)(a) is in the public interest,*

(d) notify the NHS commissioning body of the decision.

### **3.2 Integrated care board (ICB) composition should remain permissive**

#### **The issue:**

Clause 13 introduces Schedule 2 of the Bill (the model ICB Constitution). This stipulates five mandatory positions on ICBs. NHSEI's 'ICS Design Framework' requires five further positions.<sup>1</sup>

We expect further amendments to be proposed that would legally mandate further roles on ICBs. At present, however, it is welcome that under the Bill the boards will have local flexibility in determining additional members.

#### **What NHS leaders think:**

There is consensus among ICS chairs and leads that they will want to draw on expertise in areas such as public health and children and young people's services when agreeing their ICBs. Such expertise may indeed be covered within the existing mandated roles. Leaders in our ICS Network support a permissive approach to ICB membership which enables a flexible approach to appointments and avoids unnecessary prescriptions of roles on ICBs in law.

On mental health, NHS leaders across different parts of the health service, including ICS leaders, are committed to ensuring mental health care is at the heart of ICSs' work and that ICBs include mental health expertise. However, we note that there is no clear consensus on the best means of achieving this, with leaders in our Mental Health Network in favour of additional steps to advance parity of esteem for mental health, such as a legal requirement for mental health expertise on ICBs.

Voluntary, community and social enterprise (VCSE) providers (including not-for-profit community interest companies) and general practitioners are classified as sitting outside the public sector but provide an essential contribution to delivering NHS services. Should amendments be tabled to limit eligibility of ICB membership to the public sector, this may risk excluding the VCSE sector and GPs and be to the detriment of ICBs. Equally, given the wider partnership role of integrated care partnerships (ICPs), no such restrictions should be placed on ICPs.

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<sup>1</sup> [NHS England and Improvement, 'Integrated Care Systems: design framework', Version 1, June 2021.](#)

**Action / amendment required:**

Support existing clauses and oppose amendments to mandate further ICB positions, instead permitting local flexibility. Any amendment that risks restricting representatives from the VCSE sector and GPs from eligibility for ICB membership should be opposed.

**3.3 Regulation of ICSs must be lean, light and agile****The issue:**

The Bill leaves many unanswered questions about how ICSs will be regulated once they become statutory and what the role and remit of the Care Quality Commission (CQC) will be regarding system performance and quality. We do, however, expect a government amendment on the CQC's role in assessing systems.

**What NHS leaders think:**

Our members strongly oppose an overly burdensome regulatory system which risks restricting the work of health and care organisations. There are concerns from ICS leaders that a new regulatory environment – under NHSE, the CQC and now the Healthcare Services Investigation Branch – will impede their ability to adopt local approaches to improve the health and wellbeing of their local populations.

Our members have concerns that an 'Ofsted-style' ratings system for ICSs would be too simplistic, would add little value, and would demotivate systems which are focusing on safely adopting their new statutory responsibilities. Any amendment must ensure that this new role for the CQC complements rather than duplicates the role of other regulators - namely NHSEI. Our members are clear that they need a 'lean, light and agile' approach to regulation to be able to recovery equitably from the pandemic, not increased inspections and reporting from different regulators.

**Action / amendment required:**

Resist amendments that would introduce 'Ofsted-style' inspections on systems, as well as any amendments on regulation that would lead to significant bureaucracy for ICSs and/or others across the NHS.

Support amendments that require the government and the CQC to engage with NHS leaders as it develops the new regulatory framework and determines the new remit for the CQC.

## 4. The Health & Care Bill: Technical issues and areas of uncertainty

### 4.1 The role of Health & Wellbeing Boards (HWBs)

#### **The issue:**

Clause 19 (14Z52): The Bill sets out that HWBs must be involved in formulating ICB planning and strategy.

#### **What NHS leaders think:**

While a continued role for HWBs is welcomed across our membership, there are concerns about accountabilities and what the above legal requirement to 'involve' them in ICB planning and strategy will mean in practice (some systems may have multiple HWBs with different local political influences).

#### **Action / amendment required:**

We urge the committee to pose questions to the government on HWBs involvement in ICB strategy and consider amendments in the Bill if necessary. For example, do HWBs have any power of veto? Will ICBs be at liberty to proceed with a strategy even if they have consulted with HWBs in their boundaries and they are opposed?

### 4.2 ICB duties and reporting concerns

#### **The issue:**

Clause 19 of the Bill outlines several statutory duties on ICBs when exercising all their functions. For example, they must 'have regard' to the NHS constitution, service quality, efficiency and sustainability, reducing health inequalities and promoting integration, alongside many others.

#### **What NHS leaders think:**

Despite the volume of obligations, NHS leaders support and are comfortable with these duties. Clarity would be welcome on what constitutes 'having regard' to ensure that this does not necessitate an overly bureaucratic reporting process, but rather that these goals guide decision-making.

#### **Action / amendment required:**

Scrutinise collective implications of statutory duties.

### 4.3 Direction of funding powers

#### **The issue:**

Under Clause 9 the Bill gives the SoS powers to direct NHSE both about the exercise of any of its functions and its spending, stating that the SoS may direct NHS England to use finances

for 'purposes relating to service integration'. Under this clause, NHSE, in turn, may be given delegated powers to direct ICBs in how they direct funding.

**What NHS leaders think:**

Our ICS leaders are concerned about how, and how frequently, such powers may be used in future. ICBs will have a duty to deliver financial balance and will also be required to deliver progress against both their own forward plan and the strategy set by the ICP. If they are not able to direct finances autonomously then this may significantly inhibit such progress.

Similarly, there are no protections in the Bill at present against conflicts of interest. Leaders are concerned about the potential for governments to direct funding towards geographical areas that are politically important as opposed to where there is greatest need. NHS funding must be allocated in future by the ICB, based on clear formulae that aim to reduce health inequalities.

**Action / amendment required:**

To critically question the government on: how powers over the direction of funding will be used; what the implications could be for ICBs' ability to deliver against system priorities and deliver financial balance; and what measures will be in place to prevent the 'politicisation' of NHS funding. If such measures are absent or insufficient then we urge the committee to consider amendments to prevent conflict of interest.



## 5. Wider issues

### 5.1 Workforce planning

#### **The Issue:**

Clause 33 introduces a duty on the SoS to publish a report, at least once every five years, describing the system in place for assessing and meeting the workforce needs of the health service in England.

#### **What NHS leaders think:**

This proposed duty is insufficient and far too infrequent given the scale of the challenges facing health and social care and the absolute reliance on the health and social care workforce to meet those challenges.

#### **Action / amendment required:**

We would like to see the Bill go further to ensure more regular and published assessments of future workforce requirements across health and social care.

At the time of writing, an amendment to strengthen workforce planning requirements in the Bill is being developed through a coalition of health and care organisations.

While we await the final wording, we strongly support amendments to ensure that the SoS undertakes detailed assessments of future workforce requirements and which are:

- i. Based on the projected health and care needs of the population across England for 1-5 years, 5-10 years and 10-20 years.
- ii. Undertaken at least every 3 years in response to changing population needs.
- iii. Take full account of workforce intelligence, evidence and plans from integrated care systems.
- iv. Fully available in the public domain

### 5.2 Procurement regime

#### **The Issue:**

Clause 68 and 69 change procurement, patient choice and competition regulations in the NHS.

#### **What NHS leaders think:**

NHS leaders from across both the provider and commissioning sectors support the abolition of mandatory tendering which will empower health care systems to better co-ordinate care and reduce bureaucracy. We support the proposed 'New Provider Selection Regime', which

makes provision for suitable transparency and scrutiny arrangements, with only minor amendments we have put forward in our response to this Consultation.<sup>2</sup>

**Action / amendment required:**

Support existing provisions for a new Provider Selection Regime and oppose amendments for further statutory limitations on leaders to procure the most appropriate local clinical services, such as default providers rules.

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<sup>2</sup> [NHSEI, 'NHS Provider Selection Regime: Consultation on proposals', February 2021;](#) [NHS Confederation, 'NHSEI Provider Selection Regime Consultation Response', February 2021.](#)