Summary of the Department of Health and Social Care's White Paper setting out proposals for a Health and Care Bill- February 2021

1. Background and Context

1.1.1 In November 2020 NHS England and NHS Improvement released an engagement paper setting out proposals for legislation to allow ICSs to be placed on a formal footing. The Department of Health and social Care has produced a White Paper in response proposing a Health and Care Bill to be placed before Parliament with an expected date of spring 2021, with a view to it receiving royal assent in early 2022 and an expectation of implementation from April 2022.

1.1.2 The White Paper sets out the case for joining up and integrating care around people rather than around institutional silos – care that focuses not just on treating particular conditions, but also on lifestyles, on healthy behaviours and prevention.

1.1.3 At the heart of the changes being taken forward by the NHS and its partners, and at the heart of the legislative proposals, is the goal of joined up care for everyone in England. The NHS and local authorities will be given a duty to collaborate with each other, underpinned by the inclusion of local authorities on the boards of ICSs. A key responsibility for these systems will be to support place based joint working between the NHS, Local Government and other partners such as the voluntary and community sector.

1.1.4 The white paper sets the framework for integrated working, as well as identifying a number of areas where powers will be given to the Secretary of State to effect decision making. In addition, it makes a number of proposals for changes to the law to facilitate smother decision making, remove bureaucracy, restructure regulatory bodies and give the Secretary of State for Health and Social Care powers to make decisions

2. Next Steps

2.1.1 NHS England and NHS Improvement has commenced the establishment of a set of work streams to begin working on the details in readiness to support the implementation of a future Bill. The general approach is one of evolution, not revolution and of building up from the existing STPs/ICSs.

2.1.2 As part of what may be seen as a new way of collaborating, of co-designing solutions systems are being invited to engage in shaping both policy and guidance and the regional approach. The Midlands Leadership team has agreed 7 work streams covering Governance and Accountability, Joint and Integrated Commissioning, Place and Place Partnerships, Provider Collaborations, ICS financial Framework, Digital technology Data and Intelligence, People and Culture. Clinical Leadership/Involvement has been raised as a potential 8th Workstream

2.1.3 BCWB STP is seeking to be actively involved in all work streams the board is asked to note our representation as follows. Regular opportunity for discussion and debate as well as regular reports on progress will be brought to the board.

3. Work stream Suggested BCWB System Representatives

1. Governance and Accountability - Alastair McIntyre
2. Joint and Integrated Commissioning - Paul Maubach / Matt Hartland
3. Place and Place Partnerships - Brendan Clifford
4. Provider Collaboratives - Mark Axcell for Mental Health (as chair of the WM collaborative) and Richard Beeken/Diane Wake for acute services
5. ICS Financial Framework - James Green
6. Digital Technology, Data and Intelligence - Mike Hastings
7. People and Culture - Alan Duffell

4. Summary Narrative Extracted from the White Paper

4.1.1 The considerations set out in the Paper that have led to the proposed model are:

a) Place-based arrangements between local authorities, the NHS and between providers of health and care services are at the core of integration and should be left to local organisations to arrange. Where NHS England and other bodies wish to provide support and guidance they will of course do so, building on the insights already gained from the early wave ICSs. The statutory integrated care system (ICS) will also work to support places within its boundaries to integrate services and improve outcomes – recognising that different places will be at different stages of development and face different issues.

b) Health and Wellbeing Boards (HWBs) will remain in place and will continue to have an important responsibility at place level to bring local partners together, as well as developing the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy, which both HWBs and ICSs will have to have regard to.

c) A statutory ICS will be formed in each ICS area. These will be made up of a statutory ICS NHS body and a separate statutory ICS Health and Care Partnership, bringing together the NHS, Local Government and partners.

d) The ICS NHS Body will take on the commissioning functions of the CCGs and some of those of NHS England within its boundaries. Each ICS NHS body will have a board, and this will be directly accountable for NHS spend and performance within the system, with its Chief Executive becoming the Accounting Officer for the NHS money allocated to the NHS ICS Body. The board will, as a minimum, include a chair, the CEO, and representatives from NHS trusts, general practice, and local authorities, and others determined locally. ICSs will also need to ensure they have appropriate clinical advice when making decisions.

e) The ICS NHS body will be responsible for the day to day running of the ICS, and NHS planning and allocation decisions. It will be responsible for:
    - developing a plan to address the health needs of the system; and
    - setting out the strategic direction for the system and explain the plans for both capital and revenue spending for the NHS bodies in the system.

4.1.2 There is a strong case for the governance arrangements for an ICS to include an ICS Health and Care Partnership made up of a wider group of organisations than the ICS NHS Body.

4.1.3 This Partnership would be tasked with promoting partnership arrangements, and developing a plan to address the health, social care and public health needs of their system.

4.1.4 Each ICS NHS Board and Local Authority would have to have regard to this plan. The Council will be promoting collaboration and it would not impose arrangements that are binding on either party, given this would cut across existing LA and NHS accountabilities.

4.1.5 Members of the ICS Health and Care Partnership could be drawn from a number of sources including Health and Wellbeing Boards within the system, partner organisations with an interest in health and care (including Healthwatch, voluntary and independent sector partners and social care providers), and organisations with a wider interest in local priorities (such as housing providers). The intention is to specify that an ICS should set up a Partnership and invite participants, but the proposals do not intend to specify membership or detail functions for the ICS Health and Care Partnership - local areas can appoint members and delegate functions to it as they think appropriate.

4.1.6 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.

4.1.7 This, along with flexibilities at place level, will allow systems to decide how much or how little to do at these different levels and will also potentially allow them to vary these arrangements over time as the system matures and adapts.

4.1.8 The white paper is broken down into the following sections:

- Integration and collaboration
- Bureaucracy
- Public confidence and accountability
- Additional proposals – public health, social care, safety and quality

4.1.9 Within each of these sections there is further detail. However, the key points of the proposals, for the purpose of further discussion and planning, are set out below.

5. Key Points

5.1.1 Integration and Collaboration:

1. The establishment of a statutory ICS, made up of an ICS NHS Board and an 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. Each ICS will establish an ICS Health and Care Partnership, bringing together health, social care and public health. 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 board and Local Authorities will have to have regard to that plan when making decisions. This, along with the flexibilities at place level, will allow systems to decide how much or how little to do at these different levels and will also potentially allow them to vary these arrangements over time as the system matures and adapts.
2. The statutory body model for ICS decision making will merge the functions currently being fulfilled by non-statutory STPs/ICSs with the functions of the CCG. The majority of

CCG functions will be exercised by the ICS NHS Board, along with a number of commissioning functions currently undertaken by NHS England.

3. Provisions will be created for the formation and governance of the joint committees and the decisions that could be appropriately delegated to them, allowing NHS providers to form their own joint committees.
4. ICSs will be able to delegate significantly to place level and to provider collaboratives.
5. ICS NHS boards and ICS Health and Care Partnerships will be given the flexibility to develop processes and structures which work most effectively for them.
6. It will be made easier for organisations to work closely together, for example, through new proposals for joint committees and existing collaborative commissioning arrangements (such as s.75 of the NHS Act 2006).
7. ICSs will align their allocation functions with place; this will be through local determination.
8. The creation of statutory ICS NHS Boards will allow NHS England to have an explicit power to set a financial allocation or other financial objectives at a system level.
9. There will be a duty placed on the ICS NHS Board 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, however, this will also be supplemented by a new duty to compel them to have regard to the system financial objectives so both providers and ICS NHS boards are mutually invested in achieving financial control at system level.
10. There will be a reciprocal duty to collaborate on NHS organisations and local authorities, alongside a shared duty that requires NHS organisations that plan services in a local area (ICSs) and nationally (NHS England), and NHS providers of care (NHS Trusts and FTs) to have regard to the 'Triple Aim' of better health and wellbeing for everyone, better care for all people, and sustainable use of NHS resources.
11. There will be a set a capital spending limit on Foundation Trusts, which will support the third aim of the Triple Aim duty, in relation to sustainable use of NHS resources. ICSs will be allocated a system-wide capital limit, and have duties placed upon them to create a capital plan.
12. Collaborative commissioning barriers that currently exist will be removed and streamline and strengthen the governance for this type of collaborative decision-making.
13. There will be a specific power for NHS England to issue guidance on joint appointments between NHS Bodies, NHS Bodies and Local Authorities, NHS Bodies and Combined Authorities.
14. A Data Strategy for Health and Care will be forthcoming and 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.
15. Section 75 of the Health and Social Care Act 2012 Act will be repealed, including the Procurement, Patient Choice and Competition Regulations 2013 and the powers in primary legislation under which they are made will be replaced with a new procurement regime.

5.1.2 Bureaucracy:

1. Removal of the powers of the Competition and Mergers Authority for overseeing mergers and allow NHS England, as overseer of the system, to ensure that decisions can always be made in the best interests of patients.
2. Reform of the procurement of healthcare services and creation of a bespoke regime that will give commissioners more discretion over when to use procurement processes to arrange services than at present, with proportionate checks and balances. Where competitive processes can add value they should continue, but that will be a decision that the NHS will be able to make for itself.
3. Development of a new provider selection regime which will provide a framework for NHS bodies and local authorities to follow when deciding who should provide healthcare services. (This provision will be subject to public consultation).
4. Amendment of the legislation to enable the National Tariff to support the right financial framework for integration, whilst maintaining the financial rigour and benchmarking that tariff offers.
5. Allow for the creation of new NHS trusts with the overriding objective of ensuring the health system is structured to deliver the best outcomes for whole population health and respond to emerging priorities. ICSs will be able to apply to the Secretary of State to create a new trust. Any new trust will be subject to appropriate engagement and consultation (this process will be set out in guidance).
6. Local Education and Training Boards- amendment of the Care Act 2014 (which sets out the functions and constitution of HEE and LETBs) to remove LETBs from statute. LETB functions will be undertaken by HEE (and reporting to the HEE Board).

5.1.3 Ensuring Accountability and Enhancing Public Confidence:

1. Merger of NHS England, Monitor and the NHS Trust Development Authority- functions will be formally transferred to NHS England (Monitor and the NHS TDA will be abolished). This single legal entity will be called NHS England and will be answerable to the Secretary of State for Health and Social Care for all aspects of NHS performance, finance and care transformation.
2. Replacement of the current legislative requirement to have a new annual mandate each year, with a new requirement to always have a mandate in place. There will be flexibility for the mandate to be replaced to respond to changing strategic needs, emerging evidence on deliverability or appropriateness of objectives, or 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.
3. Reconfiguration of intervention power- There will be broadening of the scope for potential Ministerial intervention in reconfigurations, creating a clear line of accountability, by allowing Ministers to intervene at any point of the reconfiguration process. To support this intervention power, there will be a new process for reconfiguration that will enable the Secretary of State to intervene earlier and enable speedier local decision-making. Guidance will be issued on how this process will work as well as removing the current local authority referral process to avoid creating any

conflicts of interest. The Independent Reconfiguration Panel will, in time, be replaced by new arrangements.

4. Arms length bodies transfer of functions- There will be a power in primary legislation for the Secretary of State to transfer functions to and from specified ALBs. This mechanism will allow for review of where functions are best delivered in order to support a more flexible, adaptive and responsive system.
5. Removal of Special Health Authority time limits – the requirement to extend the existence of the five SpHAs on a three yearly basis will be abolished.
6. Workforce accountability- there will be a duty for the Secretary of State to publish a document, once every Parliament, which sets out roles and responsibilities for workforce planning and supply.

6. Additional Proposals:

6.1.1 Adult Social Care

1. The Bill will serve as a platform for detailed policy design in collaboration with stakeholders as wider reforms for the sector are implemented.
2. Social Care Data – the proposal will ensure a high response rate that will provide a high quality provider data collection.
3. Assurance- there will be the establishment of an assurance framework that will support the drive to improve the outcomes and experience of people and their families in accessing high quality care and support. There will be the introduction through the Bill of a new duty for the Care Quality Commission to assess local authorities' delivery of their adult social care duties, alongside powers for the Secretary of State to intervene and provide support where there is a risk of local authorities failing to meet these duties.
4. Direct payments to providers- the Health and Social Care Act 2008 will be amended to expand the powers of the Secretary of State (which currently allows the Secretary of State to provide financial assistance to not-for-profit bodies engaged in the provision of health or social care services in England) to allow financial assistance to be given to any bodies which are engaged in the provision of social care services in England.
5. Discharge to assess- measures to update approaches to hospital discharge to help facilitate smooth discharge will be brought forward, by putting in place a legal framework for a 'Discharge to Assess' model, whereby CHC 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.
6. A standalone power for the Better Care Fund- Legislation will amend the process for setting the NHS mandate so that it is no longer set on a rolling annual basis.

6.1.2 Public Health

7. There will be 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 (which will be retained as they have application to a wider range of bodies and, in general, are an effective mechanism in most circumstances). Doing so would create a duty on NHS England and would not rely on the need for agreement (as is the case currently).
8. Obesity- section 16 of the Food Safety Act 1990 will be amended to give Ministers the power to amend the EU Food Information to Consumers (2011/1169) regulations that

have been transposed into UK law. It is the Government's intention to introduce further advertising restrictions to prohibit advertisements for products high in fat, sugar or salt (HFSS) being shown on TV before 9pm via this Bill.

9. Fluoridation- The Secretary of State will have the power to directly introduce, vary or terminate water fluoridation schemes.
10. Reciprocal Rest of the World healthcare agreements- comprehensive reciprocal healthcare agreements with Rest of World countries to make healthcare more accessible for UK residents when they travel abroad for tourism or short-term business purposes, and support individuals with long-term conditions who usually pay higher travel insurance premia or face difficulties in getting comprehensive insurance cover.

6.1.3 Safety and Quality

11. Safety and quality- there is the proposal to take the opportunity in legislation to bring forward a range of proposals to support and enhance safety and quality in the provision of healthcare services.
12. Health Services Safety Investigations Body- there will be legislative underpinning via the establishment of an independent Health Service Safety Investigations Body to investigate incidents which have or may have implications for the safety of patients in the NHS and an Executive Non-Departmental Public Body with powers to investigate the most serious patient safety risks to support system learning.
13. Hospital food standards- the Secretary of State will be given powers to adopt secondary legislation that will implement the national standards for food across the NHS.
14. Professional regulation- there will be additional powers to widen the scope of section 60 and enable the Secretary of State to make further reforms to ensure the professional regulation system delivers public protection in a modern and effective way, that professions are regulated in the most appropriate manner and it is cost effective. This will includes Secretary of State power to abolish regulators.
15. Medical examiners – there will be amendment of existing legislation 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.
16. Medicines and Healthcare Products Regulatory Agency- the MHRA will have the power to create new national (UK-wide) medicines registries. This proposal will allow the MHRA to develop and maintain publicly funded and operated medicine registries so that patients and their prescribers, as well as regulators and the NHS, are provided with the evidence they need to make evidence-based decisions.

The White Paper will be subject to feedback and discussion which will shape the final version of the Bill that will be laid before Parliament in spring 2021. A copy of the white paper can be found here:

https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-carefor-all