Integration and Innovation:

Working together to improve health and social care for all [working title]

The Department of Health and Social Care's legislative proposals for a Health and Care Bill
TBC February 2021
Contents
[*To delete - info for drafting only]*

- The aim for this chapter is to make the case for legislation, explaining that the current legal framework needs to be improved. This was captured in the NHS recommendations for legislation to support LTP implementation

- It will acknowledge the 2012 Act, recognising the benefits of this, but accepting that the health and care system has evolved and is finding creative workarounds and innovations

- We want to build on these innovations, 'going with the grain' and support the system to run more smoothly by creating a new framework that builds on changes already being made as well as building in the flexibility to support the system to tackle challenges of the future

4. Chapter Two: Our proposals for legislation

• In this chapter we introduce our legislative proposals, grouped into the following themes:
- Integration and collaboration
- Bureaucracy
- Public confidence and accountability
- Additional proposals – public health, social care, safety and quality

5. **Chapter Three: Supporting implementation "Delivering for Patients: Implementing Innovation**" (or similar)

• This chapter will reiterate that legislation is, at best, an enabler of organisations and individuals, outlining the ways in which we hope this legislation will encourage positive behaviours and innovations, removes barriers, enable flexibility, reduces bureaucracy, and is capable of adapting over time.

- We will conclude the document with a summary of next steps, being clear that this isn't for consultation, clauses are on the way and we will continue to engage with stakeholders as we proceed.

6. Annex: Health and Care Bill Proposals - A detailed list of all the proposals in the Bill. At this time, we do not intend on including any draft clauses.
7. Annex: ICSs - Detailed explanation of what is an ICS
8. Annex: Stakeholders engaged by DHSC – list of stakeholders we have engaged with
9. Glossary

Foreword

Text TBC – Foreword from the Secretary of State

[To ensure this section aligns with the accompanying speech]

Executive summary

1. **We are living through the greatest challenge our health and care system has ever faced. The Coronavirus (Covid-19) pandemic represents an unprecedented test to health and care services, bringing intense pressure and radical change to systems, organisations and to all of us as individuals. And yet, the extraordinary dedication, care and skill of the people who work in our communities and our hospitals has been unwavering, serving as a reminder once again, of just how precious our health and care services are to us all.**

This is no ordinary moment. As we look towards the future and to the recovery of our society, our health and care system will continue to be central to our national wellbeing and prosperity in the years ahead.

2. In recent years, we have seen our health and care system adapt and evolve to meet the challenges facing health systems around the world. Not only is our population growing in size, people are also living longer but suffering from more long-term conditions.

One in three patients admitted to hospital as an emergency has five or more health conditions, up from one in ten a decade ago.

While smoking rates may be decreasing; diabetes, obesity, dementia and mental health issues are on the rise. Faced with these challenges, as well as those from Covid-19, the case couldn't be clearer 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. We need the different parts of our health and care system to work together to provide high quality health and care, so that we not only live longer lives, but live longer, healthier, active and more independent lives.

3. The Covid pandemic demonstrated plainly that this broader approach to health and care is not only desirable, but essential. We have seen first-hand how different groups have been impacted in different ways by Covid-19, and how wider factors play a part in our health outcomes. Our legislative proposals capture the learning from the response to the pandemic to support the NHS to deliver in a way that is more integrated, less bureaucratic, and more accountable. Building on the NHS's own proposals in their Long Term Plan, our proposals will make permanent some of the innovations where Covid-19 has forced the system to improvise new and better ways of working. They will remove the barriers to people working together better.

4. We have seen real progress in how organisations across the health and care system have been collaborating with each other and with local government and local partners in recent years and the Covid pandemic has in many places accelerated this approach.

It is this joined up, integrated care that will be vital in tackling the factors that affect the long-term sustainability of patient services. Integrating care has meant more patients are seeing the benefits of joined up care between GPs, home care and care homes, hospitals and mental health services.

For staff, it has enabled them to work outside of organisational silos, deliver more patient-centred and personalised approaches to care, and tackle the bureaucracy that stands in the way of providing the best care for people.

The experience of the pandemic has made the case for integrated care even stronger and has redoubled the government's determination to ensure that public health, social care and healthcare work more closely together in the future than ever before.

And so, this White Paper sets out our proposals for legislation to support and enable the health and care workforce, organisations and wider system to work together to improve, integrate and innovate.

Working together to integrate care

5. At the heart of the changes being taken forward by the NHS and its partners, and at the heart of our 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 integrated care systems. These systems will work to integrate care both within the NHS – bringing together different NHS organisations to make collective decisions, solve shared problems and to decide on the use of NHS resources – and

working with local authorities to tackle shared problems; address wider determinants of health and support people to live healthier lives.

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.

Frequently, place level commissioning within an integrated care system will align geographically to a local authority boundary, and the Better Care Fund (BCF) plan will provide a tool for agreeing priorities. This will be further supported by other measures including improvements in data sharing and enshrining a 'triple aim' for NHS organisations to support joint working through shared aims around population health, patient outcomes and value for taxpayers.

Reducing Bureaucracy

6. Stakeholders have said that existing legislation is overly detailed and prescriptive in some areas. We intend to reform the existing legislation to support the workforce by creating the flexibility NHS organisations need – to remove the barriers that prevent them from working together and to enable them to arrange services and provide joined up care in the interests of patients.

Bureaucracy has a role to play but it should not stifle innovation.

We will put pragmatism at the heart of the system. Enabling the NHS and local authorities to arrange healthcare services to meet current and future challenges by ensuring that patient and taxpayer value – and joined up care – are first and foremost. This will require changes to both competition law as it was applied to the NHS in the 2012 Health and Social Care Act and the system of procurement applied to the NHS by the legislation.

These changes will enable the NHS and local authorities to avoid needless bureaucracy in arranging healthcare services while retaining core duties to ensure quality and value. This will be supported by further pragmatic reforms to the tariff and to remove the statutory requirement for Local Education and Training Boards.

Improving accountability and enhancing public confidence

7. We are also bringing forward several measures to improve accountability in the system in a way that will empower organisations and give patients and the public the confidence that they are receiving the best care from their health and care system, every time they interact with it.

The de facto development in recent years of a strongly supportive central NHS body in the form of a merged NHS England and NHS Improvement will be placed on a statutory footing and will be designated as NHS England.

This will be accompanied by enhanced powers of direction for the government over the newly merged body which will support great collaboration, information sharing and ensure that decision makers overseeing the health system at a national level are effectively held to account.

In addition, we will legislate to further ensure the NHS is able to respond to changes and external challenges with agility as needed.

Measures will include reforms to the mandate to NHS England to allow for more flexibility of timing; the power to transfer functions between arm's length bodies and the removal of time limits on Special Health Authorities.

The experience throughout the pandemic has reiterated the importance of accountability, and that the public and Parliament expect to be able to hold to account the decision makers responsible for health and care. Our measures recognise this, and we therefore plan to introduce greater clarity in the responsibility for workforce planning and a clear line of accountability for service reconfigurations with a power for Ministers to determine service reconfigurations earlier in the process than is presently possible.
Other measures

8. We also intend to bring forward other measures to support social care, public health and the NHS. For social care, these will include measures to enhance assurance, allow direct payments to providers, facilitate data sharing and improve discharge processes. For public health we intend to legislate to tackle several issues including advertising of unhealthy food product and fluoridation of drinking water.

We are also putting in place legislation to enable the implementation of comprehensive reciprocal healthcare agreements with countries around the world.

Finally, we plan to bring forward measures that contribute to improved quality and safety in the NHS, including placing the Health Services Safety Investigations Body on a statutory footing; Medical Examiners; and allowing the Medicines and Healthcare products Regulatory Agency to set up national medicines registries.

9. As we set out in chapter one, legislation is best seen as an enabler of change that is most effective when combined with other reforms and drivers of change within the health and care system.

We have seen the NHS adapt in recent years, developing innovations to support more joined up care and to tackle bureaucracy. This provides a foundation to build upon and our aim is to use legislation to provide a supportive framework for health and care organisations to continue to pursue integrated care and other sources of value for patients and taxpayers in a pragmatic manner. As the system emerges from the pandemic, these legislative measures will assist with recovery by bringing organisations together, removing the bureaucratic barriers between them and enabling the changes and innovations they need to make.

10. On current timeframes, and subject to Parliamentary business, our plan is that the legislative proposals for health and care reform outlined in this paper will begin to be implemented in 2022. This means they will form a critical part of the recovery process from the pandemic, and so we must ensure that our approach is enabling and flexible. Many of the lessons of the pandemic are clear, but it will take time to fully understand them all. We need to combine the realism required in recognising we do not know all the answers with the urgency of working to successfully apply the insights we do have as soon as possible. Legislation can only ever be part of the picture, and will need to support and accompany wider reforms in areas such as data and finance which will play a key role in the years ahead to meet the changing needs of the population, to deal with the challenges caused by the pandemic, and tackle the health inequalities exposed by Covid-19.

Our Health and Care System
Since the creation of the NHS in 1948 our health and care system has continued to grow and evolve to meet our health and care needs.

[To be formatted]
The challenges
GRAPHICS AND TEXT HERE
Achievements
GRAPHICS AND TEXT HERE

Chapter One: The role of legislation

11. In a typical 24-hour period, the NHS in England will see 1 million patients in GP appointments and carry out over 26,000 operations. In the social care system, local authorities are supporting almost 150,000 older people and over 40,000 young people in care homes as well as over 440,000 people in the community. Behind those numbers there are many stories of hope, vulnerability, care and healing; and of health and care services that have empowered and helped people to live fulfilling lives. These stories are the work of the dedicated staff who make our NHS and our care system what it is, and the real experiences of the people behind the statistics.

12. How many of those health and care staff on that typical day consult, discuss or even think about the legal framework the health and care system operates within? Or how many people are aware of the patchwork of legislation that applies to the NHS and social care system? Hardly any, of course, and there is no reason why they should. The legal framework for the health and care system should be like any operating system – the sort of thing you tend not to notice when it is working well.

13. It is, however, clear that some elements of the current legal framework need to be improved. The lessons from the pandemic cannot and should not be ignored, we need the right legislative framework to support the recovery and meet the challenges of the future. A great deal of the changes required were captured in the NHS's recommendations to Government and Parliament for an NHS Bill. These described the legislative changes the NHS needed to help it to deliver the improved outcomes set out in the NHS Long Term Plan, both published with broad support in 2019.

14. Legislative change can bring real benefits when it helps to remove barriers, provide flexibility and clarify roles. That is precisely what we are seeking to do with these proposals. The measures outlined in this document are designed to make it easier for NHS organisations and their partners to work together to tackle the issues that matter most to the people they serve; to help them move from being 'importers of illness to exporters of health' to quote former Chief Medical Officer Sally Davies .

Legislation can help to create the right conditions, but it will be the hard work of the workforce and partners in local places and systems up and down the country that will make the real difference. This does not just apply to legislation for the NHS, and we have sought to develop our legislative proposals with the whole of the health and care system in mind.

15. A central theme in the NHS's own Long Term Plan is the importance of joint working with colleagues in Local Government and elsewhere. It is clear that neither the NHS nor Local Government can address all the challenges facing whole population health on their own.

The ambition to reduce inequalities and support people to live longer, healthier and more independent lives will demand bold joint and cohesive efforts. As well as closer working at a local and system level, in some cases, proportionate national legislative intervention on public health measures must play its part.

16. We also recognise that the social care system needs reform: this remains a manifesto commitment and the Government intend to bring forward separate proposals on social care reform this year. No one piece of legislation can fix all the challenges facing health and social care – nor should it try – but it will play an important role in meeting the longer-term health and social care challenges we face as a society.

17. In bringing forward these measures, we are determined to make the changes to legislation the NHS asked for and, given the government's wider responsibilities for public health and social care, we intend to take forward a set of targeted legislative measures to support social care, public health and safety and quality. These proposals capture the initial learning from the experience of the health and care system in responding to the pandemic and makes permanent some of the innovations where Covid-19 has forced the system to improvise new and better ways of working. They provide a framework which allows rather than prohibits further evolution.

18. Legislation of all kinds needs to be carefully calibrated to make only necessary and proportionate changes. The risk of legislative overreach and of an excessive specification of detail, spelling out the exact conditions under which specific organisations can and cannot work together, can lead to bureaucracy and confusion for those faced with the task of implementation.

As the pandemic has shown, there is a great deal of insight, commitment and innovation in local organisations.

We need a legislative framework that builds on the trust we have for those within systems to understand and deliver what their populations need.

19. Integration is a good example of this: we can legislate to make it easier to integrate care, but the hard work will fall to local organisations. In so many areas integration is already happening.

Even before the pandemic, many local system leaders were seeing huge benefits from joining up across health and local authorities. The NHS and local authorities in local areas worked together to make the move from hospital to care settings more seamless for individuals.

Within local areas, the NHS has worked closely with Directors of Public Health – the experts on the health of their local populations - to develop more sophisticated approaches to population health management. And some areas found that more intractable problems – like addressing the needs of homeless people – were best addressed together, with the NHS and local authorities working as a team to support an individual's physical, mental and economic needs.

It is clear from this that the culture of the health and care system is changing – there is a strong recognition in many organisations that joined up care and partnership working is critical to improving the lives of the people in England in the years and decades ahead.

20. Our proposals will help to create a new framework that builds on the changes already made by the health and care system itself and which will better enable the system to tackle the challenges of the future. Beyond the legislative proposals set out in this document, there are several other changes to the health and care system – including improved data sharing, financial arrangements to support integration and improvements to public health services – that our proposals are designed to support and to align with. An outward-looking, more connected and integrated health and care system focused on population health, public wellbeing and innovation is possible, and we know it is possible because it is already happening in lots of places. Our proposals are designed to enhance, support, spread and encourage the changes that are already underway to make joined up care a reality for all.

Chapter Two: Our proposals for legislation

[To be formatted]
The challenges
GRAPHICS AND TEXT HERE
Achievements
GRAPHICS AND TEXT HERE

21. In January 2019, the NHS published their Long Term Plan which sets out the priorities for health and care over the next ten years. This plan, developed in partnership with those who know the NHS best – frontline health and social care staff, patients and their families and other experts - suggested targeted legislative proposals that would help to support the implementation of the objectives described in the Long Term Plan.

22. Following the publication of the Long Term Plan proposals for legislation, the NHS engaged with the public, patients, NHS staff and a broad range of representatives from across the health and social care sectors on possible legislative changes.

There were more than 190,000 responses to this engagement exercise and in September 2019, NHS England published their final recommendations.

A number of influential organisations and individuals wrote to the Government in broad support. These recommendations were supported in a letter to Government, including NHS Providers, Unison, the Local Government Association, the Academy of Medical Royal Colleges, National Voices and others.

23. NHS England's proposals form the foundation of this Bill. Their recommendations for legislation were designed around three important principles that still stand today: any legislation should solve practical problems; avoid a disruptive top down reorganisation; and have broad consensus within the system. The majority of our proposals either directly implement or build upon NHS England's recommendations. Where we have built upon NHS England's proposals this is because we have explored some developments since the original NHS England publication and the experience of the pandemic suggests there is a case to go further.

24. Whilst NHS England's 2019 proposals form the core of this legislation, Covid-19 has taught us that in some areas we might need to go further to reach our objective of supporting whole population health. So, we have also added some additional proposals in a number of key areas that fall within the broader remit of the Secretary of State for Health and Social Care. These proposals relate to public health, social care and quality and safety matters. Whilst the majority of these proposals are England only, in some case they would apply to the Devolved Administrations (DAs). We will continue to engage with DAs on all of the proposals in this paper. As stated above, it is important that this legislation responds to the NHS' asks of government, but it is also important that the legislation looks beyond just the NHS, to the whole health and care system, to ensure that together, the system can deliver improved outcomes for the people who rely on it. Whilst this legislation is not the vehicle for wholesale social care or public health reform, we have sought to use it to address specific problems, where legislative change could be beneficial.

25. The proposals we have developed can be grouped under the following themes: working together and supporting integration; stripping out needless bureaucracy; enhancing public confidence and accountability; and additional proposals to support social care, public health, and quality and safety. The first three themes directly implement or build on the proposals made by NHS England to government as part of its 2019 engagement exercise on legislative proposals. The final theme includes additional proposals which DHSC consider appropriate to bring forward in this Bill, to complement NHS England's

proposals and support the wider health and care system.

a) Working together and supporting integration: enabling different parts of the health and care system to work together effectively, in a way that will improve outcomes and address inequalities.

Working together and supporting integration proposals:

1. Integrated Care Systems
2. Duty to Collaborate
3. Triple Aim
4. Power over Foundation Trusts Capital Spend Limits
5. Joint committees
6. Collaborative Commissioning
7. Joint Appointments
8. Choice
9. Data Sharing

The Covid-19 pandemic demonstrated starkly the importance of different parts of the health and care system working together in the best interests of the public and patients. This has been something that organisations in the health and care system have been increasingly working towards over the past few years, despite the barriers in legislation which sometimes make it difficult to do so. We propose to implement NHS England's recommendations and legislate to support integration, both within the health service, and between the health service and local government, with its statutory responsibilities for public health and social care.

We want to legislate for every part of England to be covered by an integrated care system (ICS).

This is in line with NHS England's recommendation in their recent document, formally recognising the need to bring together NHS organisations, local government and wider partners at a system level to deliver more joined up approaches to improving health and care outcomes.

This will be supported by a broad duty to collaborate across the health and care system and a triple aim duty on health bodies, including ICSs, as recommended by NHS England. This will require health bodies, including ICSs, to ensure they pursue simultaneously the three aims of better care for all patients, better health and wellbeing for everyone, and sustainable use of NHS resources.

As an additional safeguard for financial sustainability, we will take a power to impose capital spending limits on Foundation Trusts, in line with NHS England's recommendation.

We will implement NHS England's recommendations to remove barriers to integration through joint committees, collaborative commissioning approaches and joint appointments, as well as their recommendation to preserve and strengthen the right to choice within systems. We will also legislate to ensure more effective data use across the health and care system, which is critical to effective integration.

Further detail on our proposals for integrated care systems is set out at Annex B, encompassing both the legislative and the non-legislative arrangements we intend to put in place. This is one of the most important elements of the legislative proposals, and we have sought to understand the hopes and concerns of a range of stakeholders in framing them. We have been particularly mindful of the importance of places within systems and of the enormous potential for joint working and innovation between local government and health partners that many of the vanguard integrated care systems have already demonstrated, while also recognising the distinct accountabilities of NHS bodies and Local Government.

Case Study - How does integration impact on patients?

Greater integration of services across the NHS, voluntary sector and local authority has enabled Cambridgeshire and Peterborough to provide more effective support to people experiencing a mental health crisis.

By establishing a community-based mental health crisis First Response Service (FRS), the county has been able to provide responsive support for anyone experiencing mental health crisis.

Before the service was launched, there was no capacity to see people in need of mental health care out of hours, except via A&E. And there was no self-referral route, meaning many sought help direct from A&E.
Open 24/7, the FRS provides support for people of all ages across Cambridgeshire and

Peterborough. It welcomes self-referrals as well as urgent referrals from carers, GPs, ambulance c

rews, police and the emergency department. The result has been a 20% reduction in the use of the emergency department for mental healthcare and a 26% decrease in the number of people with mental health needs being admitted to acute hospitals from the emergency department.

It has also resulted in fewer ambulance call-outs, assessments and conveyances to the emergency department and reduced the need for out of hours GPs to see people in mental health crisis.

b) Stripping out needless bureaucracy: turning effective innovations and bureaucracy-busting into meaningful improvements for everyone, learning from innovations during Covid-19 Reducing Bureaucracy proposals:

1. Competition
2. Procurement
3. National Tariff
4. New Trusts
5. Removing Local Education Training Boards (LETBs)

In line with NHS England's recommendations, we want to strip out unhelpful rigidities in the legislation, where they fail to enhance accountability, or necessitate complex or bureaucratic workarounds and make it difficult for the system to integrate and adapt over time as needed.

Covid-19 has presented a unique opportunity and imperative to drive real change in this area, building on the innovation and cultural shift that was already underway in many places.

When the pandemic struck, the NHS, the social care sector and partners were quick to cut through some of the bureaucracy that had accumulated over a number of years.

Whether it was in relation to data sharing, flexible workforce deployment, decision making / governance, or integrated delivery; in many parts of the country, system leaders set aside bureaucratic barriers to respond swiftly to the challenges of the pandemic. Whilst some of these changes are only appropriate as part of an emergency response, others demonstrated how removing bureaucracy could lead to better outcomes in more normal times. We need to build on the trust that we know we can place on frontline staff and their organisations, to enable them to deliver better outcomes and experiences for people that use health and care services.

The Department of Health and Social Care's paper, Busting bureaucracy: empowering frontline staff by reducing excess bureaucracy in the health and care system in England, sets out the Government's strategy for reducing excess bureaucracy.

These actions are being taken forward through a variety of different projects, some led by the department, some by regulators and some by other bodies across the health and care system. Whilst we can do a lot to reduce bureaucracy through changing processes and culture, the Department's engagement demonstrated that a lot of bureaucracy is also generated by inflexible, prescriptive or out-dated legislation and we therefore want to use this opportunity to amend legislation to resolve these issues.

In line with the requests made by the NHS, we will use legislation to remove much of the transactional bureaucracy that has made sensible decision-making in the system harder.

T**he NHS should be free to make decisions on how it organises itself without the involvement of the Competition and Markets Authority** (CMA).

We will also reform procurement of NHS services and create a bespoke health services provider selection regime that will give commissioners greater flexibility in how they arrange services than at present. The NHS will be consulting on the new regime shortly.

Where procurement processes can add value they will continue, but that will be a decision that the NHS will be able to make for itself. These new flexibilities will be reinforced by changes to the tariff to enable the tariff to work more flexibly within system approaches; the creation of New Trusts to ensure alignment within an integrated system where that is helpful. In line with the aim of reducing the need for bureaucratic workarounds, and increasing flexibility and adaptability in the system, the government is also proposing one additional measure not put forward by NHS England in their paper: the removal of Local Education Training Boards (LETBs) from

statute to give Health Education England (HEE) more flexibility to adapt its regional operating model over time.

The impact of reducing bureaucracy on the workforce

Our consultation reviewed what bureaucracy looks like in the health and care system. It found that NHS staff felt that unnecessary bureaucracy is time-consuming, frustrating and stressful, largely because they felt it took them away from patient care.

Social care workers agreed. Social care managers were less vocal about the frustration of unnecessary bureaucracy.

Our legislative reforms will reduce bureaucracy and promote collaboration across the health and care system. We will legislate to make procurement more flexible because we have seen the benefits of streamlining procurement for the workforce:

Streamlined procurement in Manchester.

Following the 2012 reforms, re-tendering and re-procurement have become much more frequent to meet competition regulations, even when they are won repeatedly by the same organisation.

In order to overcome this hurdle, the Local Government Association shifted the procurement window of a project on homelessness in Manchester from 3 to 7 years. The new re-procurement period allowed the organisation to retain staff, think longer term about the project and to consider innovative solutions that had been impossible before because of time constraints.

c) Enhancing public confidence and accountability: ensuring that we have the right framework for national oversight of our health system, that national bodies are streamlined, with clear roles and responsibilities, and that the public and Parliament can hold decision makers to account

Ensuring accountability and public confidence proposals:

1. Merging NHS England, Monitor and the NHS Trust Development Authority
2. Power of Direction over NHS England (the newly merged body)
3. The NHS Mandate
4. Reconfigurations intervention power
5. Arm's Length Bodies (ALB) Transfer of Functions
6. Removing Special Health Authorities Time Limits
7. Workforce Accountability

Both the public and Parliament rightly expect to be able to hold decision makers who oversee the health and care system to account.

Our legislative proposals focus on ensuring that our accountability arrangements command public confidence, whilst also enabling systems to get on with doing their jobs and making appropriate changes to enable transformation and innovation. This means ensuring that the framework for national oversight of the NHS is fit for purpose now and into the future.

The original set of national NHS bodies has already altered in form and purpose, and in the legislation, we intend to continue the work already undertaken to formally bring together NHS England and NHS Improvement into a single legal organisation.

DHSC will be seeking to build on NHS England's proposals by ensuring the new body, with its increased scope and centralised decision-making capacity, can be held to account in an appropriate way.

The pandemic has highlighted the need to balance national action with local autonomy.

The adaptations of recent years have led to the concentration of decision-making in a relatively small number of national NHS bodies. This has created an imbalance in the system which will be counterbalanced in this legislation by the strong role that Integrated Care Systems will play and by greater clarity about the role of Government and of Parliament.

The Department will have a critical role to play in overseeing the health and care system and in ensuring strong alignment and close working between public health, healthcare and social care.

The Department will support the independence and accountability of ICSs, and the Secretary of State for Health and Social Care will have an important role in ensuring

that integration across health, public health and social care is working effectively within these systems.

This will be enabled, where appropriate, by a power to direct NHS England (the merged body) and a more flexible mandate for NHS England, which will make it easier for the Secretary of State to set objectives for the body.

In addition, when it comes to significant service change, some Parliamentarians have criticised the current system for a lack of accountability and timely access to decision-making for them.

We therefore intend to create a clear line of accountability back to the Secretary of State, by including a provision to allow the Secretary of State to intervene in service reconfiguration changes where required.

We also intend to legislate to ensure a more agile and flexible framework for national bodies that can adapt over time. There are no current plans to change or transfer functions of the bodies in the system (with the exception of the changes we are making to merge NHS England and NHS Improvement, and changes arising from the establishment of the National Institute for Health Protection and related reforms to public health).

Almost half of respondents agreed to this proposal in NHS England's consultation, although some felt the strategic intent of the proposal was unclear.

The Government is proposing additional safeguards, which will enable further scrutiny if this power is used. The Government is also proposing to bring forward measures to remove the unnecessary 3-year time limit for Special Health Authorities from legislation.

Whilst not specifically considered in NHS England's previous recommendations, it is a measure which will support a more flexible framework for national bodies and remove unnecessary limitations from the legislation.

Finally, we are proposing to introduce a Secretary of State duty to publish a report every Parliament which will support greater clarity around workforce planning responsibilities, which reflects the concerns raised by the Royal College of Nursing in response to NHS England's publication and will support the aim of greater clarity in how national bodies operate.

d) Additional proposals to support social care, public health, and quality and safety. Additional proposals:

Social Care

1. Assurance
2. Data
3. Direct payments to providers
4. Discharge to assess
5. A standalone power for the Better Care Fund

Public health

6. Public Health power of direction
7. Obesity
8. Fluoridation
9. Reciprocal healthcare agreements with Rest of World countries

Safety and Quality

10. Health Services Safety Investigations Body (HSSIB)
11. Professional Regulation
12. Medical Examiners
13. Medicines and Healthcare products Regulatory Agency (MHRA) new national (UK wide) medicines registries
14. Hospital food standards

We have developed an additional series of targeted proposals which will improve social care, public health and quality and safety.

These complement the measures we are putting in place in response the NHS's requests to Government.

The proposals are not intended to form a coherent reform package in themselves (as stated above, reforms to social care and public health will be dealt with outside this Bill), but are intended to address specific problems or remove barriers to delivery, maximise opportunities for improvement, and have in some cases been informed by the experience of the pandemic.

On social care: we will bring forward measures on system assurance and data, to ensure that there are appropriate levels of oversight on the provision and commissioning of social care; a payment power, which corrects a limitation in existing legislation preventing the Secretary of State for Health and Social Care making payments to all social care providers; and proposals that provide greater flexibility when discharging patients

from a hospital to a care setting for assessment.

We will also create a standalone power for the Better Care Fund, separating it from the NHS mandate setting process.

Case study: Improving patient discharge
University Hospitals of Derby and Burton Foundation Trust has "revolutionised" the way it discharges patients to ensure that they are the ones to benefit from not spending any more time in hospital than is absolutely necessary.

The Trust has changed the way that it discharges patients from hospital during the Covid-19 pandemic to help speed up the process of helping patients go home or on to their next place of care safely.

More emphasis has been placed on staff to quickly identify those who are medically fit to leave hospital and ensure the patient is transferred to our discharge areas within one hour, where they can then be assessed and arrangements can be made to have them picked up within a two hour window.

Nearly quadruple the number of patients are now being discharged in this way each day from Royal Derby Hospital to before, while around double the amount of applicable patients are now also coming through the Discharge Lounge at Queen's Hospital Burton, compared to before.

A larger Discharge Assessment Unit (DAU) replaced the Discharge Lounge at Royal Derby Hospital at the start of April, and the team have made some amazing improvements to patient experience, with an average of 58 people being discharged each week day.

The DAU, which mainly cares for patients who are being discharged back home and not onto further care in the community, also sees an average of 26 patients a day at weekends, with most spending just an hour and a half on the unit in total.

The Integrated Discharge Team, which is made up of community assessment nurses, discharge support officers, social services and community therapists working within the DAU, have played a key role in speeding up the process for those patients who need to be transferred to their next point of care in the community.

By completing discharge assessments from the unit and enabling patients to be transferred from the wards as soon as they are clinically stable to do so, lengthy delays that may have taken place before have now been reduced, resulting in a better experience all round for our patients.

Lisa Marshall, Discharge and Integration Manager, said: "This new model has revolutionised the way that we assess patients for discharge. Due to the two-hour target set by the Covid-19 discharge guidance, it was clear that we needed to radically change how the usual processes for discharge worked, so that we ensured our patients didn't spend any more time in hospital than absolutely necessary.

"*The success of the Discharge Assessment Unit would not have been possible without the buy in from the Integrated Discharge Team and our partners in Derbyshire Community Health Services, and Adult Social Care in Derby and Derbyshire. Our integrated team of nurses, porters, pharmacy, admin and medical colleagues have also been key to helping ensure we meet the highest standards of patient care and experience – it truly has been a team effort.*

"*We've seen a huge improvement to the way we discharge patients and it is our patients who have been the ones to benefit from this, which we're extremely proud about.*"

The Discharge Lounge at Queen's Hospital Burton has also been relocated to a bigger site to provide extra space and capacity for patients and staff, with the changes resulting in patients spending an average of less than an hour and a half in the lounge waiting to be discharged.

Separate Covid-19 and non-Covid-19 areas have been set up within the discharge units across both sites to limit the chance of the virus being spread, with the move helping the Trust to discharge more than 660 Covid-19 patients since 1 April.

This change to UHDB's discharge process was originally introduced in response to Covid-19 but, having seen the extremely positive impact it has had on patient care, the new model could now be retained by the Trust going forward.

Gavin Boyle, Chief Executive, said:

"*The Covid-19 pandemic has required us all to work differently in so many ways; some for the better, which we'll definitely want to keep. The way we've transformed our discharge processes to reduce our patients' stay in hospital is a great example of this and we're delighted with the results we've seen so far. "The Discharge Assessment Unit has now nearly quadrupled the numbers of patients discharged using this new process with most leaving our hospitals in under an hour and a half. Anyone who has worked in the NHS will understand that this is quite an achievement. To see the teams completely change how they work to improve the experience for our patients is fantastic and makes me very proud to be able to work alongside such dedicated and forward-thinking colleagues*."

On public health: we will bring forward measures to make it easier for the Secretary of State to direct NHS England to take on specific public health functions (complementing the enhanced general power to direct NHS England on its functions); help tackle obesity by introducing further restrictions on the advertising of high fat, salt and sugar foods as well as a new power for Ministers to alter certain food labelling requirements. This will ensure consumers can be supported to make more informed, healthier choices about their food and drink purchases.

In addition, we will be streamlining the process for the fluoridation of water in England by moving the responsibilities for doing so, including consultation responsibilities, from local authorities to central Government.

And we will take powers to implement comprehensive reciprocal healthcare agreements with countries outside the EEA and Switzerland ('Rest of World countries') – expanding our ability to support the health of our citizens when they travel abroad, subject to bilateral agreements. These measures on public health will complement and augment the efforts of ICSs to make real inroads in improving population health in their areas, helping to tackle inequalities and 'level-up' across communities.

On safety and quality: we will bring forward measures to put the Healthcare Safety Investigation Branch (HSIB) on a statutory footing; to enable us to streamline the current regulatory landscape for healthcare professionals as needed; to establish a statutory medical examiner system within the NHS for the purpose of scrutinising all deaths which do not involve a coroner, and to allow the Medicines and Healthcare products Regulatory Agency (MHRA) to develop and maintain publicly funded and operated medicine registries so that we can provide patients and their prescribers, as well as regulators and the NHS, with the evidence they need to make evidence-based decisions.

We will also be bringing forward measures to enable the Secretary of State to set requirements in relation to hospital food.

Chapter Three: Delivering for all - supporting implementation and innovation

26. This White Paper represents a significant milestone on the journey towards achieving our objective of supporting everyone to live healthier and fulfilling lives for longer but bringing forward legislation is only part of the story.

27. For people using the NHS regularly, it will support their GP and hospital consultants to work together to arrange treatment and interventions that prevent illness or preventing their conditions deteriorating into acute illness.

This population health approach will be informed by a better data, drive understanding of local populations, identifying those who are at risk and who we can impact and designing a more proactive way of delivering care.

It will mean that social care providers can receive emergency financial support when needed to prevent instability in care for the most vulnerable people in our communities.

For staff working across the NHS, public health and social care, it should mean that there are fewer bureaucratic hurdles to overcome when they are just trying to do their job.

It will support hospitals, GPs, local councils and voluntary partners to work together to plan how they will address the health needs of their populations in the years ahead, so that over time the people we care for don't get ill as quickly or as badly. And it will ensure that the quality and safety of NHS care continues

to improve, with investigations of things that go wrong so mistakes can be learned from.

28. To be effective, legislation must, of course, be implemented. This process is most effective when the legislation in question is both well-designed to serve its core purpose and fits with other features of the system that remain in place.

Our proposals seek to go with the grain of what the system is already doing and the positive changes that have been increasingly evident in recent years – its adaptability, collaborative instincts and its ability and determination to always find a way.

The measure of the success of legislative change will not be the permanent casting of the system in a single form, but the acceleration of its ability to learn, adapt and improve.

29. Our legislative proposals are designed to support and accelerate positive changes within the system.

This will also require the use of non-legislative means, including having the right workforce in place; setting out clear guidance; and getting the incentives and financial flows right.

In order to be successfully implemented, our proposals will therefore be supported by an implementation programme that recognises the importance of a range of key non-legislative enablers in facilitating change. We will want to work closely with the system in developing this implementation programme.

30. This legislation is also not intended to address all the challenges faced by the health and social care system. The Government is undertaking broader reforms to social care, public health and mental health which will support the system in helping people to live healthier, more independent lives for longer. These reforms are not included in our proposals for this Bill but are part of a wider Departmental strategy.

31. The Department recognises the significant pressures faced by the social care sector and remain committed to reform. We want to ensure that every person receives the care they need and that it is provided with the dignity they deserve.

Our objectives for social care reform are to enable an affordable, high quality and sustainable adult social care system that meets people's needs, whilst supporting health and care to join up services around people.

A broad range of options are being explored for how best to accomplish these reform objectives, and we have committed to bringing forward proposals this year.

In the meantime, the proposals contained within this bill will embed improvements that have been made to the system as it has adapted to address needs arising from Covid-19 and ensure that the legislation reflects best practice in the sector.

32. Our experience of the pandemic underlines the centrality to our health system and indeed our society of a population health approach: preventing disease, protecting people from threats to health, and supporting individuals and communities to improve their health and resilience.

The Government will publish in due course an update on proposals for the future design of the public health system which will create strong foundations for the whole system to function at its best.

These changes are driven by learning from the experiences of Covid, but more broadly by the need to ensure we have a public health system fully fit for the future.

The factors which prevent poor health are shaped by many different parts of government, public services and the broader health system.

So rather than containing health improvement expertise within a single organisation, driving change in the future will mean we need many different organisations to have the capability and responsibility for improving health and preventing ill health.

33. In January, the Department of Health and Social Care and the Ministry of Justice published Reforming the Mental Health Act, a White Paper which responds to the Independent Review of the Act, chaired by Professor Sir Simon Wessely in 2018. This forms our plan to modernise mental health legislation.

There is a clear case for modernisation and change. The White Paper sets out our proposals for a substantive programme of

legislative reform, taking forward the Government's commitment to legislate to give people greater control over their treatment, and ensure they are treated with the dignity and respect they deserve.

It also takes forward our commitment to improve how people with a learning disability and autistic people are treated in law and reduce the reliance on specialist inpatient services for these groups.

We want everyone to have the opportunity to live a full and rewarding life in their communities and an end to perpetuated detentions without appropriate therapeutic inputs.

34. In forming our proposals, we have been able to draw upon the work done by NHS England as part of its Long Term Plan process and upon the insights generated by the extensive engagement that NHS England undertook in formulating its proposals.

We have supplemented this with a number of further engagement conversations with stakeholders on both specific issues and on the wider lessons of both the pandemic and the more evolutionary changes experienced by the health and care system in recent years.

35. On current timeframes, and subject to Parliamentary business, our plan is that these proposals for health and care reform will start to be implemented in 2022. We will continue to engage with stakeholders across the health and care systems, our Arm's Length Bodies and the Devolved Administrations on the detail of these proposals as they progress.

36. In due course, we will be publishing an Equalities Impact Assessment, an updated Impact Assessment and draft clauses.

Annex A: Proposals for legislation
Theme One: Working together and supporting integration

These proposals are about enabling different parts of the health and care system to work together effectively, in a way that will improve outcomes and address inequalities.
Working together and supporting integration proposals:

1. Establishing Integrated Care Systems
2. Duty to Collaborate
3. Triple Aim
4. Power over Foundation Trusts Capital Spend Limits
5. Joint committees
6. Collaborative Commissioning
7. Joint Appointments
8. Data Sharing
9. Choice

Establishing Integrated Care Systems (ICSs) in law

Integrated Care Systems (ICSs) have become an increasingly familiar part of the health and care landscape in recent years.

Many of the vanguard ICSs have been highly successful in bringing partners together to improve outcomes for the public, often supporting and supplementing arrangements at place level.

Existing ICS arrangements are based on voluntary arrangements, rather than legislative provision, and are therefore dependent on goodwill and mutual co-operation.

There are also legislative constraints on the ability of organisations within an ICS to make decisions jointly. While several systems have found ways to establish effective governance models, there are some obstacles and limitations in the current legal framework which inhibit this.

For example, there is no legal basis at present for CCGs, NHS trusts and FTs to form a joint committee, to which functions may be delegated, with the power to make decisions on behalf of the organisations within the ICS.

In order for ICSs to progress further, legislative change is now required to give ICSs stronger and more streamlined decision-making authority, and to embed accountability for system performance and delivery into the accountability arrangements of the NHS to Government and Parliament.

The legislative provisions that we propose for Integrated Care Systems are designed to provide a small set of consistent requirements for each system that the partners who make up that system can then supplement with further arrangements and agreements that suit them.

The role of ICSs in supporting integration both within the NHS and between the NHS and its partners in Local Authorities along with further

detail on the purpose and governance of Integrated Care Systems is set out at Annex B.

In this section we set out the core functions of the ICS along with a number of other provisions designed to support integration across the health and care system.
We are proposing to establish statutory ICSs, made up of an ICS NHS Board and a 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.

The ICS NHS Board 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.

Each ICS will also be required to establish a ICS Health and Care Partnership, bringing together health, social care, public health (and potentially representatives from the wider public space where appropriate, such as social care providers or 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 board and Local Authorities will have to have regard to that plan when making decisions.

Based on the experience of Covid-19 and the lessons learnt about system integration, and following the consultation exercise led by NHS England, we have developed a statutory body model for ICS decision making which merges the functions currently being fulfilled by non-statutory STPs/ICSs with the functions of a CCG.

We aim to bring the allocative functions of CCGs into the ICS NHS body so that they can sit alongside the strategic planning function that we would like the ICS to undertake.

This will enhance accountability and allow the members of the ICS to develop integrated and innovative approaches to deliver strategic objectives. Our proposals would also, in line with the approach set out by NHS England, allow for ICSs to delegate significantly to place level and to provider collaboratives. We therefore propose that the majority of CCG functions to be exercised by the ICS NHS Board, as well as a number of commissioning functions currently undertaken by NHS England, for example taking on responsibility for commissioning some specialised, primary care and other services currently commissioned by NHS England.

We also want ICS NHS Boards to have the ability to delegate some of its functions, either to individual providers or to groups of providers and/or others.

In practice, we recognise that ICSs will have to develop effective and legitimate decision making processes, and we are giving ICS NHS boards and ICS Health and Care Partnership the flexibility to develop processes and structures which work most effectively for them.

We will develop and issue further proposals on this, working in collaboration with NHS England.

We know that we need to support staff during organisational change by minimising uncertainty and limiting employment changes. We are therefore seeking to provide stability of employment and will work with NHSE and staff representatives to manage this process.

A key responsibility of the ICS will be working in partnership with other local bodies, both within the health and social care system, and more widely.

In order to facilitate this, we will make it easier for organisations to work closely together, for example, through our new proposals for joint committees (see below) and existing collaborative commissioning arrangements (such as s.75 of the NHS Act 2006).

This joint approach to working will also be supported by the “triple aim duty” (see the proposal below).

The ICS will also have to work closely with local Health and Wellbeing Boards (HWB) as they have the experience as ‘place-based’ planners, and the NHS ICS board 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.

ICSs will also want to think about how they can align their allocation functions with place, though we are leaving this to local determination.

NHS Trusts and Foundation Trusts (FTs) will remain separate statutory bodies with their functions and duties broadly as they are in the current legislation.

The creation of statutory ICS NHS Boards will also allow NHS England to have an explicit power to set a financial allocation or other financial objectives at a system level.

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.

We know there has been excellent progress in some areas in making a reality of integrated care. We also know that this has sometimes been in spite of the systems we ask people to work within, and that it is far from universally true that integration is proceeding in step with the needs and lives of the people we serve.

We have therefore – with the help of NHS England's work following the Long Term Plan – identified a several further changes to reinforce or enable integration. Details of the NHS's proposals, which we have bolstered with an additional duty to collaborate, are set out below.

Duty to collaborate

Alongside the creation of statutory ICSs, we intend to introduce a new duty to promote collaboration across the healthcare, public health and social care system. Many existing duties on health and care organisations emphasise the role of the individual organisation and its own interests. We want to rebalance these duties to reflect the need for all health and care organisations to work collaboratively. When collaboration works well it leads to better outcomes for people, for example a successful early intervention can lead to people living independently and in their own homes for longer.

This proposal will place a reciprocal duty to collaborate on NHS organisations and local authorities. This policy also provides the Secretary of State for Health and Social Care with the ability to issue guidance as to what delivery of this duty means in practice, in recognition of the fact that collaboration may look very different across different kinds of services.

We intend for this single duty to collaborate to replace the two current duties to cooperate in legislation to support our wider ICS policy, where we expect local authority and NHS bodies to work together under one system umbrella. The duty will apply to:

- NHS England (the newly merged body);
- ICSs;
- NHS Trusts;
- NHS Foundation Trusts (FTs);
- Special Health Authorities (SpHAs);
- National Institute for Health and Care Excellence (NICE);
- Health and Social Care Information Centre (NHS Digital);
- Health Education England (HEE);
- Upper Tier Local Authorities.

Triple Aim

To further support integration, we propose to implement NHS England's recommendation for 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.

This will support NHS bodies to continue a culture of working together in the best interest of not only their immediate patients and organisations, but of the wider population, and for the ICS as a whole, working together strategically and through its 'place'- based constituents, also to address the wider determinants of health as part of an agreed plan.

We hope that the Triple Aim will help align NHS bodies around a common set of objectives thus supporting the shift towards integrated systems which have strong engagement with their communities.

Power over Foundation Trusts Capital Spend Limit

We are also planning to implement NHS England's recommendation for a power to 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.

Unlike NHS Trusts, which are set annual capital expenditure limits by NHS Improvement, NHS Foundation Trusts (FTs) currently have additional freedoms to borrow from commercial lenders and spend surpluses on capital projects (e.g new buildings, equipment or IT).

However, capital expenditure by FTs still counts towards DHSC's overall capital delegated expenditure limit (CDEL).

In recent years, given the restraint on capital expenditure and a growing maintenance backlog, the Department of Health and Social Care have had to restrict capital expenditure by Trusts and temporarily delay capital projects to ensure that we do not breach our CDEL limit.

A small number of FTs have previously indicated that they could push ahead with their individual schemes and use their own capital, without full consideration of the overall impact on the ICS and on CDEL as a whole.

This could mean that at ICS or national level we may have to pause other schemes which may be strategically more beneficial or clinically required.

Dialogue is the first line of defence and remediation locally and nationally, but a targeted power is required as a last resort to protect the system and ensure the most sustainable use of NHS resources.
As we embed a new capital regime where

Integrated Care Systems (ICS) are allocated a system-wide capital limit, and have duties placed upon them to create a capital plan, we are seeking powers in the Bill to be able to set legally-binding Capital Departmental Expenditure Limits (CDEL) for individual, named Foundation Trusts (FTs), where they are not working effectively to prioritise capital expenditure within their ICS, and risk breaching either system or national CDEL limits.

How will this be delivered?

• NHS England would notify the FT in question of its proposal to set a limit and the FT would be able to make representations.

- If having considered the representations, NHS England decides to proceed, it would need to make an order specifying the FT on which the limit was to be imposed, the amount of that limit and the financial year or part year to which it relates.

- The order would be laid before Parliament but would not be a statutory instrument nor would it be subject to any Parliamentary control. The order should be laid by NHS England.

- When laid before Parliament, the order would have to be accompanied by a written statement by NHS England setting out:

(a) why it considered imposition of the limit necessary,
(b) what steps it had taken to avoid having to impose a limit and
(c) the representations made by the FT in response to the proposal for the limit.

As well as laying before Parliament, NHS England would be required to publish the order and accompanying statement (e.g. on its website).

Joint Committees

As NHS England set out in their engagement document, legislation does not currently allow NHS providers (NHS trusts and foundation trusts) and CCGs (which will become ICSs) to take joint decisions, either through a joint committee or committees-in-common, or for local authorities and other providers of NHS care to be involved in such partnership arrangements.

Furthermore, foundation trust boards and individual directors have a duty to act with a view to promoting the success of their organisation.

This creates an unhelpful barrier to joint working, and commissioners and providers currently have to use workarounds with complex governance arrangements in order to jointly discuss integrated care, incurring legal risk and administrative cost.

While our ICS body provisions go most of the way to increasing the ease with which providers and commissioners could establish joint working arrangements and support the effective implementation of integrated care. We consider that NHS England's recommendation to allow ICSs and NHS

providers to create joint committees would be a useful addition, removing unnecessary barriers to joined-up decision making.

We are therefore proposing to create provisions relating to the formation and governance of these joint committees and the decisions that could be appropriately delegated to them; and separately, allowing NHS providers to form their own joint committees.

Both types of joint committees could include representation from other bodies such as primary care networks, GP practices, LAs or the voluntary sector.

Collaborative Commissioning

We want to support the health and care system to work collaboratively and flexibly across different footprints.

Many local areas have been exploring ways of working more collaboratively and are seeking to align decisions and pool budgets between CCGs and NHS England, across CCGs, and between CCGs and local authorities (LAs).

Existing legislative mechanisms make it difficult to do this, forcing local systems to adopt complex workarounds to be able to make lawful decisions across a wider population footprint. In practice, these arrangements can be cumbersome, difficult to manage and can slow decision-making processes.

We intend to implement NHS England's recommendation to change the legislation to remove these barriers and streamline and strengthen the governance for this type of decision-making.

These proposals will:

• Give NHS England the ability to allow groups of ICSs to collaborate to arrange services for their combined populations.
• Allow ICSs to carryout delegated functions, as if they were their own, to avoid the issue of '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 s.7A public health services, *for example national screening and immunisation programmes*, with one or more ICSs, or groups of ICSs. It will also enable NHS England to jointly commission these services with an ICS to carry out that function.
• Enable NHS England to delegate Specialised Commissioning arrangements to ICSs or jointly commission these services including providing the ability to pool budgets in relation to specialised commissioning.

Joint appointments

To support closer working between actors in the health and care system, greater clarity is needed to enable joint appointments across different organisations.

Joint appointments of executive directors can help to foster joint decision making, enhance local leadership and improve the delivery of integrated care.

They can also help to reduce management costs and engender a culture of collective responsibility across organisations.

In line with NHS England's recommendation, we are proposing to introduce a specific power for NHS England to issue guidance on joint appointments between NHS Bodies; NHS Bodies and Local Authorities; and NHS Bodies and Combined Authorities.

This will aid the development and delivery of integrated care and will ensure that there is a clear set of criteria for organisations to consider when making joint appointments.

NHS England will need to keep the guidance under review, and if substantial changes to it are considered, they will need to consult appropriate organisations before the revision is published.

Data sharing

Building on the successful data sharing in response to Covid-19, we want to ensure that health and care organisations use data, when they can do so and with appropriate safeguards, for the benefit of individuals and the wider health and social care system.

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, we are exploring where achieving these objectives may require primary legislation.

This includes proposals to:

i) require health and adult social care organisations to share anonymised information that they hold between themselves where such sharing would benefit the health and social care system.

ii) introduce powers for the Secretary of State for Health and Social Care to require data from all adult social care providers about all services they provide (whether funded by local authorities or privately by individuals). These are discussed further in the Adult Social Care proposals.

iii) make changes to NHS Digital's legal framework to introduce a duty on NHS Digital to have regard to the benefit to the health and social care system of sharing data that it holds when exercising its functions; and clarify the purposes for which it can use data.

iv) introduce a power for the Secretary of State for Health and Social Care to mandate standards for how data is collected and stored, so that data flows through the system in a usable way, and that when it is accessed/provided (for whatever purpose), it is in a standard form, both readable by, and consistently meaningful to, the user/recipient.

Choice

Integrated services provide an opportunity to offer joined up care to all and provide clear information on the choices people have in how and where their care is delivered.

A patient's right to choose where and who will provide their health and care needs will be preserved and strengthened in the new system arrangements.

The NHS's Long-Term Plan (LTP) makes specific proposals to strengthen patient choice and control, including the roll out of personal health budgets. The LTP states that the ability of patients to choose where they have their treatment remains a powerful tool for delivering improved waiting times and patient experiences of care.

The LTP also states that the NHS will continue to provide patients with a wide choice of options for quick elective care, including making use of available Independent Sector capacity.

The protections and rights in relation to patient choice and the AQP (Any Qualified Provider) requirements are fundamentally set out in the current legislation.

As part of the wider package of changes to procurement policy, we propose to repeal section 75 of the Health and Social Care Act 2012 Act including the Procurement, Patient Choice and Competition Regulations 2013 and replace the powers in primary legislation under which they are made with a new procurement regime.

Under the new model, bodies that arrange NHS Services as the decision-making bodies will be required to protect, promote and facilitate patients choice with respect to services or treatment. We also want to make clearer the rules, circumstances and processes around the operation of Any Qualified Provider (AQP).

We will take forward the NHS's recommended approach by retaining existing patient choice rights and protections and bolstering the process for AQP arrangements.
In addition, ICSs can be powerful drivers of patient centred approaches that provide greater choice and control to patients by transforming services around the specific needs of their populations.

We 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.

We 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.

Theme Two – Reducing Bureaucracy

Stripping out needless bureaucracy, turning effective innovations and bureaucracy-busting into meaningful improvements for everyone, learning from innovations during Covid-19. Reducing Bureaucracy proposals:

1. Competition
2. Procurement
3. National Tariff
4. New Trusts
5. Removing Local Education Training Boards (LETBs)

The Department's recent Busting Bureaucracy exercise showed how bureaucracy can act as a barrier to the frontline when delivering care.

We want to remove those barriers and use our legislation to give people in the system the flexibility to work together to improve services for everyone. We also want to remove unhelpful rigidities in the legislation, which have necessitated complex and often bureaucratic workarounds and made it difficult for the system to adapt over time as needed.

Competition

The Health and Social Care Act 2012 put a regime in place which put competition as the organising principle for improvement in NHS care.

This has in some cases hindered integration between providers. In practice, the NHS has not operated as the market intended by the 2012 Act.

Alongside this, the Competition and Markets Authority (CMA) were given specific powers to review mergers involving Foundation Trusts (FT).

It has become clear that the CMA is not the right body to review NHS mergers. In line with NHS England's recommendations, we intend to remove these powers and allow NHS England, as overseer of the system, to ensure that decisions can always be made in the best interests of patients.

The CMA's jurisdiction over mergers is UK-wide, so we are working with the devolved administrations to ensure there would be no unintended consequences of these proposals.

Building on the experience of the last few years, we now want to take forward proposals to legislate to clarify the central role of collaboration in driving performance and quality in the system, rather than competition. The proposals are to:

i) Remove the CMA function to review mergers involving NHS foundation trusts. The CMA's jurisdiction in relation to transactions involving non-NHS bodies (e.g. between an NHS Trust/ FT and private enterprise) and other health matters (e.g. drug pricing) would be unchanged.
ii) Remove NHS Improvement's specific competition functions and its general duty to prevent anti-competitive behaviour to support NHS England's role as an improvement agency, rather than a regulator.
iii) Remove the need for NHS England to refer contested licence conditions or National Tariff provisions to the CMA

Alongside the role of competition in service improvement, it is also right that (as the newly merged body) NHS England's main role is on supporting improvements in health outcomes, the quality of care and use of NHS resources.

Procurement

The NHS has sent us a clear message that the current procurement regime for healthcare services is not working.

It is confusing, overly bureaucratic and does not support the integration and efficient arrangement of services in the best interest of patients.

In line with the requests made by NHS England, which garnered strong support from the wider system, we will use legislation to remove much of the transactional bureaucracy that has made sensible decision-making and collaboration in the system harder.

We will reform procurement of healthcare services and create 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.

The procurement reforms within the Bill will remove the current procurement rules which apply for NHS and public health service

commissioners when arranging healthcare services.

They will do this by creating the powers 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 powers within the Bill are intended to enable us 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 services.

This will be informed by the public consultation which will begin shortly, and aims to enable collaboration and collective decision-making, recognising that competition is not the only way of driving service improvement, reduce bureaucracy on commissioners and providers alike, and eliminate the need for competitive tendering where it adds limited or no value.

Commissioners of NHS and public healthcare services will be under duties to act in the best interests of patients, taxpayers, and the local population when making decisions about arranging healthcare services.

We anticipate that there will continue to be an important role for voluntary and independent sector providers, but we want to ensure that where there is no value is running a competitive procurement process that services can be arranged with the most appropriate provider.

The NHS will continue to be free at the point of care and our proposals seek to ensure that where a service can only be provided by an NHS provider e.g. A&E provision, that this process is as streamlined as possible.

These reforms will only apply to the procurement of healthcare services – including public health services whether commissioned solely by a Local Authority or jointly by the Local Authority and NHS as part of a S75 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 legislation for the National Tariff allows a substantial degree of flexibility, in what is a complex area – but it was in part designed to further implement a system of 'payment by results' or payment by activity, as part of the wider 2012 Act reforms, and in some respects its provisions may not always best facilitate new payment approaches to support collaboration.

As we move towards a system of ICSs focused on population health, we want to ensure that the payment system supports that direction of travel.

The set of proposals relating to the National Tariff are intended to implement NHS England's recommendations and update the legislative requirements to reflect and support the drive towards greater integration in healthcare; make adjustments that remove barriers to desired pricing approaches; and simplify and streamline the pricing process.

Experiences during the pandemic have also demonstrated the positive impact that financial frameworks can have on facilitating joint working.

We will take forward NHS England's proposals on the National Tariff, by amending 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. This includes:

i) 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
ii) NHS England could amend one or more provisions of the national tariff during the period which it has effect, with appropriate safeguards.
iii) Remove the requirement for providers to apply to NHS Improvement for local modifications to tariff prices
iv) NHS England should be able to include provisions in the National Tariff on pricing of NHS public health services under section 7A agreements.

New Trusts

We are not seeking to significantly alter the provider landscape; however, NHS England's recommendations to government included a provision to allow the creation of new trusts for the purposes of providing integrated care.

We agree that there may be merit in creating a new trust for that purpose, but the experience of Covid-19, including the creation of the Nightingale hospitals, has demonstrated that there may be other circumstances when the Secretary of State may want to create a new trust.

Consequently, we intend to allow 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.

This is in line with our overarching aim to ensure the system is flexible and adaptable into the future, and wherever possible avoids the need for complex workarounds to deliver system priorities.

We are therefore bringing forward measures that will enable ICSs 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.

Removing Local Education Training Boards (LETBs)

The collaborative working between Health Education England (HEE), NHS England and NHS Improvement and the Department on the development of the NHS People Plan has shown the need for a flexible and future-proofed regional workforce operating model.

In light of this work, we have reviewed the role of Local Education and Training Boards. These were originally established in 2012 as statutory sub-committees of HEE to perform HEE's functions at local and regional level by ensuring effective regional planning systems for the planning and delivery of education and training.

In addition, LETBs had a direct role in commissioning the education and training required at local level, a role which has diminished following the 2017 education funding reforms. However, LETB functions are restricted by legislation which has limited their scope to adapt and interact with the regional directorates of NHS England and Improvement and the newly established non-statutory Regional Workforce and People Boards (which now provide an architecture consistently across England for oversight of Workforce, Education and Training).

We are proposing to amend the Care Act 2014 (which sets out the functions and constitution of HEE and LETBs) to remove LETBs from statute.

We believe removing LETBs from statute with their functions continuing to be undertaken by HEE (and reporting to the HEE Board) will provide HEE with the flexibility to adapt its regional operating model over time.

Accompanied with our proposal (*see para X*) for the Secretary of State for Health and Social Care to take a statutory duty to publish a document outlining the workforce planning and supply system at national, regional and local level, this measure will provide clarity over responsibilities.

While LETBs operate only in England, we will work with DAs should this proposal have any UK-wide impact.

This proposal was not directly recommended by NHS England, but it flows as a consequence of the changes being recommended by NHS England to encourage more system working, and fits with our plans to ensure the legislative framework is not overly rigid or restrictive, and can adapt over time as needed.

Theme Three – Ensuring Accountability and enhancing public confidence.

Enhancing public confidence by ensuring that we have the right framework for national oversight of our health system, that national bodies are streamlined, with clear roles and responsibilities, and that the public and Parliament can hold decision makers to account.

Ensuring Accountability and enhancing public confidence proposals

1. Merging NHS England, Monitor and the NHS Trust Development Authority
2. Powers of Direction over NHS England (the newly merged body)
3. The NHS Mandate

4. Reconfigurations intervention power
5. Arm's Length Bodies (ALB) Transfer of Functions
6. Removing Special Health Authorities Time Limits
7. Workforce Accountability

Merging NHS England, Monitor and NHS Trust Development Authority

In their recommendations to Government, NHS England recommended that NHS England and NHS Improvement should be permitted to merge fully, as requested by both their boards and strongly supported in the engagement responses.

As NHS Improvement currently consists of the NHS Trust Development Authority (NHS TDA) and Monitor, we are proposing to formally transfer their functions to NHS England and abolish Monitor and the NHS TDA.

Over the last two years, we have seen NHS England and NHS Improvement come together to work effectively as a single organisation.

We have seen clear benefits from them working in practice as one organisation providing national leadership: speaking with one voice, setting clearer and more consistent expectations for providers, commissioners and local health systems; removing unnecessary duplication; using collective resources more efficiently and effectively to support local health systems and ultimately making better use of public money.

Despite the success of NHS England and NHS Improvement's joint working programme, there are limits to how far they can fully collaborate under the current legislation.

For example, both organisations have separately been assigned some distinctive and non-shareable functions in legislation – they are currently required to have separate Boards, Chairs, CEOs and non-executive directors and still consist of three separate employers. Despite the efforts of both organisations to find practical arrangements and 'work-arounds', these restrictions and governance arrangements prevent the organisations from fully operating as one single organisation.

By bringing forward this proposal, we will remove these bureaucratic and legislative barriers, enabling the organisation to legally come together as one to provide unified national leadership for the NHS. 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.

Power of Direction over NHS England

This legislation will allow NHS England and NHS Improvement to legally come together as one single organisation, merging together their responsibilities to better support the NHS to deliver improved care for patients.

As local health systems work more closely together, the same needs to happen at a national level.

The proposed changes to the national architecture will be accompanied by a clear and strengthened democratic oversight and clarity for decision making throughout the system.

The NHS England of 2022 is a very different organisation with a significantly different role to the NHS Commissioning Board of 2013.

Recognising this shift, we are proposing to create a power of direction over NHS England that will provide clear lines of accountability by allowing the Secretary of State for Health and Social Care to direct NHS England in relation to relevant functions.

As a newly merged body, NHS England will, of course, remain answerable to the Secretary of State for Health and Social Care and Parliament for all aspects of NHS performance, finance and care transformation.

By bringing forward this proposal, we want to strengthen the Secretary of State's powers of intervention, oversight and direction. This will serve, in turn, to reinforce the accountability to Parliament of the Secretary of State and Government for the NHS.

Covid has reinforced the importance of and increased need for clear and unified lines of accountability from the front-line to Parliament.

The public and Parliament (rightly) expect decision makers overseeing the health system to be accountable for the performance of the

NHS. The public and patients need to know that when issues arise, and when people need answers to their concerns, there are systems in place to address the issues at the appropriate level.

While that is likely to almost always be done within the system rather than by Ministers, there will be occasions when it will be appropriate for Ministers to play a more direct part in relation to NHS England, and this proposed power would structure such interventions and ensure Minister are accountable for them.

It will also support the Secretary of State to set clear direction in a more agile way, and to do so formally as well as informally as required.

The ability to provide a formal direction to NHS England in order to manage an emerging or difficult issue will sit alongside the strong and effective informal arrangements for working together that have evolved between the Department and NHS England in recent years. It has become clear that the more 'hands off' role for Government with respect to NHS England that was framed in the 2012 Act has not been realised in practice, and it is therefore appropriate to add this formal power of direction to the informal ways of working that are now in place.

This power will not allow Secretary of State to direct local NHS organisations directly nor will it allow the Secretary of State to intervene in individual clinical decisions.

The NHS Mandate

Each year the Government publishes the NHS mandate, a document which sets out the objectives which NHS England should seek to achieve. The NHS mandate is intended to set strategic direction for the NHS by setting out the top priorities that the Government expects NHS England to focus on delivering. These objectives are carried through to NHS England's planning guidance.

When NHS England, Monitor and the NHS Trust Development Authority are legally merged, the current statutory mandate to NHS England will cover the whole of the combined organisation.

At present, the process for setting, publishing and replacing the mandate is linked to the financial cycle and takes place annually.

Before the start of each financial year, the Secretary of State for Health and Social Care must publish and lay before Parliament the NHS mandate.

However, this annual cycle has become problematic as it does not align with timescales for other strategic decisions that should influence and align with the mandate's content.

To allow the mandate to set direction over a longer term and in a more strategic way than currently permitted by the annual cycle, we are 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.

It will also provide the flexibility for the mandate to be replaced to respond to changing strategic needs, emerging evidence on deliverability or appropriateness of objectives, or external events, rather than having to wait until the next annual opportunity.

Given we will be removing the link between the mandate and the annual financial cycle, 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.

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.

This proposal will not impact on Parliament's ability to scrutinise the mandate – each new mandate will continue to be laid in Parliament by the Secretary of State and will be published.

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. Furthermore, 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.

Healthwatch England's involvement ensures that all NHS mandates are informed by the needs of patients and the public.

Reconfigurations intervention power

Reconfigurations involve changing how NHS services are delivered in a way that impacts on patients; this can range from smaller changes such as the closure of a GP surgery, to larger changes such as the replacement of several stroke units with a centralised hyper acute unit.

Many service changes happen by consent locally -planned reconfigurations are currently developed at local or regional levels (and sometimes, nationally) by commissioners. The current system for reconfigurations works well for the most service changes, and so this will remain in place for the majority of day-to-day transactions.

Where it does not work well, however, is in cases which are a significant cause for public concern or are particularly complex. Inevitably some can be more controversial and can lead to difficult – even intractable – debate and processes that stretch on for years.

The Secretary of State is currently able to intervene in such cases upon receiving a Local Authority referral and may commission the Independent Reconfiguration Panel to provide recommendations. After receiving these, the Secretary of State will communicate his final decision.

Whilst this can help with difficult cases, referrals can often come very late in the process. This can lead to difficult debates and lengthy processes, meaning a long and arduous journey to a decision being made and local areas and their democratic representatives are left in limbo.

Information on reconfigurations in the system can also often be incomplete and take a long time to reach Ministers for various reasons. This leaves Ministers in the position of having to account for service changes in Parliament without having been meaningfully engaged on them themselves.

In the context of Covid-19, the situation on reconfigurations (especially temporary ones) is integral to understanding both system resilience and the strengths and weaknesses of recovery plans.

We are therefore proposing to broaden 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, we will introduce a new process for reconfiguration that will enable the Secretary of State to intervene earlier and enable speedier local decision-making.

This will seek to address the issue of a democratic deficit throughout the process. We will issue guidance on how this process will work as well as removing the current LA referral process to avoid creating any conflicts of interest. T

his would mean that the Independent Reconfiguration Panel, will, in time, be replaced by new arrangements. Since its establishment in 2003, the Independent Reconfiguration Panel has provided advice to the Secretary of State on over 80 cases and we will learn from the work of the IRP as we develop processes that build on lessons and principles for achieving successful service change.

We do not anticipate this power being used with great frequency 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 power

Looking beyond just NHS England, to the wider national landscape, we have seen the Department's Arm's Length Bodies, with all their differing functions and operations, respond rapidly to the Covid pandemic and demonstrating immense flexibility.

From the outset, core activities were streamlined whilst new Covid-19 related work programs were implemented. We have seen our ALBs working more closely together in collaborative ways in order to support and improve people's health and care.

It is important that when needed, we can support our ALBs to work flexibly, make it easier for them to respond to future challenges, and provide clarity about who is responsible and accountable for various functions.

Therefore, we are proposing to create a power in primary legislation for the Secretary of State for Health and Social Care to transfer functions to and from specified ALBs.

This mechanism will allow us to review where functions are best delivered in order to support a more flexible, adaptive and responsive system.

In cases where an ALB becomes redundant as a result of transfer of its functions, this power will also include the ability to abolish the remaining ALB. The power to transfer functions and the power to abolish an ALB will be only be exercisable via a Statutory Instrument (SI) following formal consultation.

Devolved administrations will be consulted from the outset so that provision can be made for their approval of any transfer of functions that are operative within their nations.

In the responses to NHS England's engagement exercise, stakeholders sought further detail and clarity about what the power could be used. This power is designed to provide greater resilience to future system stresses, and to support and foster the flexibility that ALBs have shown in dealing with the pandemic.

It will allow the system to adapt and shift to changes in priorities and focus over time, rather than having to introduce complex and bureaucratic workarounds (as we have seen between NHS England and NHS Improvement for example).

There is no immediate plan to use this power. Use of this power will be subject to a full, open and transparent process throughout. Before this power can be used, a formal consultation will be required.

The Secretary of State will also need to consider any recommendations made by Parliamentary Committees, and both Houses of Parliament would need to approve the proposal. This process will ensure that the ALBs, the wider health and care system, and Parliament will have the opportunity to scrutinise any plans for its use, and to ensure that any movement of functions is right for health and care system and the public.

Special Health Authorities time limits

We greatly value our Special Health Authorities (SpHAs) and the work that they do. There are currently five SpHAs, each with their own distinct and important roles.

These include the NHS Business Services Authority (NHSBSA), the NHS Trust Development Authority (TDA), NHS Blood and Transplant (NHSBT), NHS Resolution (NHSR) and the NHS Counter Fraud Authority (NHSCFA).

Currently, existing legislation sets an automatic expiry dates on our SpHAs which requires us to formally extend their existence every three years. This is a time consuming and bureaucratic process that creates unnecessary administration costs for the SpHAs.

This proposal will remove the three-year time limit on all SpHAs. Not only is this time limit is unnecessary as the functions of the SpHAs are enduring, it is also inconsistent as the time limits only impact a select few SpHAs such as NHS Blood and Transplant and NHS Business Services Authority which have existed since 2005.

By removing this time limit, we are ensuring all SpHAs are treated equally in legislation and removing the bureaucratic, time consuming and duplicative process.

Workforce Accountability

The Department is proposing to create a duty for the Secretary of State for Health and Social Care to publish a document, once every Parliament, which sets out roles and responsibilities for workforce planning and supply.

This document would:

• cover the NHS including primary, secondary, community care and where sections of the workforce are shared between health and social care e.g. registered nurses, and health and public health e.g. doctors and other regulated healthcare professions.
• describe the workforce planning and supply system including the roles of DHSC and its

Arm's Length Bodies, NHS bodies and others and how they work together.
• not give any bodies additional functions to those they already have in statute,
• be co-produced with (at a minimum) Health Education England and NHS England.

The purpose of this document is to set out in one document the current roles and responsibilities in order to provide greater transparency.

Theme Four: Additional proposals

The following additional proposals are designed to support social care, public health and safety and quality.

Social care

1. Data
2. Assurance
3. Direct payments to providers
4. Discharge to assess
5. A standalone power for the Better Care Fund

Public health

6. Public Health power of direction
7. Obesity
8. Fluoridation
9. Reciprocal healthcare agreements with Rest of World countries

Safety and Quality
10. Health Services Safety Investigations Body (HSSIB)
11. Hospital food standards
12. Professional Regulation
13. Medical Examiners
14. Medicines and Healthcare products Regulatory Agency (MHRA) new national (UK-wide) medicines registries

Proposals relating to social care

The Bill represents just one step in a programme of positive reform for the Adult Social Care sector. Our proposed legislative measures will embed improvements that have been made to the system as it has adapted to address needs arising from Covid 19.

They will grant us a greater ability to respond flexibly to the needs of the sector while adapting and developing existing practice in a way that does not place undue burden on local authorities or social care providers.

The Bill will also serve as a platform for detailed policy design in collaboration with stakeholders as we move forward on wider reforms for the sector.

These legislative measures are one aspect of a wider reform agenda and are not intended to address every issue faced by the sector. As stated above, we remain committed to wider social care reform, with proposals to be published this year.

ICS and Adult Social Care

ICS legislation will complement and reinvigorate place-based structures for integration between the NHS and Social Care, such as Health and Well-Being Boards, the Better Care Fund and pooled budget arrangements.

Legislation will do this by firstly creating a more clearly defined role for Social Care within the structure of an Integrated Care System (ICS), with a clear place in ICSs for Local Authorities.

This will give ASC a greater voice in the overall health and care system, and will provide a springboard for closer integration and collaborative working between health and social care on a local level; supported by formal duties in the Bill for NHS ICSs Boards to have regard to HWB plans.

This is crucial; meaningful integration that makes patient and user journey's smoother, will continue to be prioritised, and ICSs offer a system-level, strategic complement to this.

This process will be aided by published guidance that will offer support for how ICSs can be used to align operating practices and culture with the legislative framework to ensure ICSs deliver for the ASC sector.

Putting ICSs on a statutory basis will also act as a foundation for future work to shape ICSs as they develop, to ensure that they effectively promote integration between health and care at place level, as well as improving integration within the NHS.

The active involvement of the sector in this work going forwards will be hugely important in ensuring that ICSs deliver for adult social care.

Improve the quality and availability of data across the Health and Social Care Sector

Improved data and data flows are needed alongside our assurance system. We need to make changes to the data we collect and the frequency with which we collect it; not just for central government assurance and oversight, but so that Local Authorities, providers and consumers can access the data they need while minimising the burden on data providers.

Building on improvements made by existing tools such as the capacity tracker implemented during the pandemic and an increased ability to gather data from social care providers (for local authority and privately funded care), we will remedy gaps in available data and help us to understand capacity and risk in the system.

This will enable us to judge when and how to target support to providers and ultimately help facilitate the care of individuals across the care system.

In response to the pandemic we established data flows from providers that have helped us respond to outbreaks but our high response rates have been linked to funding for infection prevention, we need the legislation to ensure we continue to have a high response rate that will provide a high quality provider data collection.

Long-standing gaps in coverage in data on social care both from local authorities and from care providers have prevented us from making the evidence-based case for system change.

With better provider data we will be able to make more informed workforce policy interventions, knowing where workforce gaps are in terms of numbers and skills.

One of the key gaps in our existing data from Local Authorities is around those who self-fund their care.

By collecting data from providers we will be able to better understand the needs and demographics of self-funders. Understanding fees paid by LAs and self-funders will help identify unmet need and support the case for additional funding.

Data on hours of care services provided and their cost per person, together with data on financial flows will show how money flows to providers and workforce. With client level data, we can make links with health data and use it to improve our understanding of the lifetime cost of care. This will also support improved cooperation and joint decision-making between health and social care partners in delivering shared outcomes.

With more and better data, we can plan the future care of our population and will have the potential to generate significant health benefits such as increased independence, improved quality of care and higher patient satisfaction.

Improved data can also benefit recruitment, retention and equality policies within the sector workforce. We want high quality data, collected to agreed high standards and meeting the needs of all users. It should be collected once to reduce reporting burdens and shared, maximising the use of technology and used intelligently to support commissioning and delivery of high-quality services.

A new assurance framework for social care

Demographic change has resulted in more people turning to social care and we expect this trend to continue for the foreseeable future.

Local authorities are at the forefront of our response to this challenge, and we welcome their commitment to providing high quality outcomes as envisaged through the Care Act 2014, placing an emphasis on personalisation, choice and early intervention.

As social care affects a greater number of people at some point during their lives, accountability for services becomes increasingly important for both national and local government. National Government has played an increasingly important role in the funding of Adult Social Care and needs to be confident that this funding is spent as intended to improve adult social care outcomes.

We want to work with Local Authorities and the sector to establish an assurance framework that will support our drive to improve the outcomes and experience of people and their families in accessing high quality care and support, regardless of where they live.

To support these goals we are proposing to introduce through the Health and Care Bill 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.

Our plan is 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, providing a long-term basis of consistent oversight with the goal of reducing variation in the quality of care.

We understand that these proposals come following an extraordinarily challenging year for adult social care, which is why our initial focus will be to improve the quality, timeliness and accessibility of adult social care data, with the assessment of local authority provision of adult social care to be introduced over time as the final element of the assurance framework.

Provide a power for the Secretary of State for Health and Social Care to make payments directly to providers.

The Coronavirus pandemic has demonstrated the need for speed and flexibility in providing support to the social care sector. Coronavirus has also clearly demonstrated how unforeseen and quickly changing circumstances can require fast and innovative intervention, and we need to be prepared to meet any need of the sector in the future.

We are therefore legislating to amend the Health and Social Care Act 2008 to expand the powers of the Secretary of State for Health and Social Care, 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.

The Bill will widen this to allow financial assistance to be given to any bodies which are engaged in the provision of social care services in England.

The Bill will not prescribe in what circumstances the power can be used, or how it should be provided. Instead, this power will act as a legal foundation for future policy proposals, as and when required. Any such proposals may provide grants, loans, loan guarantees or the purchase of share capital on any terms the Secretary of State considers appropriate.

The type of assistance will be determined on a case-by-case basis and may range from a single payment to one provider, or multiple payments to the entire sector.

However, we are clear that this power will not be used to amend or replace the existing system of funding adult social care, where funding is provided via Local Authorities. Instead,

it will only be used to provide funds that are not already accounted for within regular social care funding, including in response to emergency or unforeseen circumstances, or to cover specific additional costs that the sector requires.

Discharge to assess

We will bring forward measures to update approaches to hospital discharge to help facilitate smooth discharge, 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.

This change will help to embed good practice guidelines which have been followed over the past few years, as well as the national policy that has been pursued throughout Covid-19.

Providing a legislative basis for this model allows for the safe discharge of individuals into an environment familiar to them, enabling a more appropriate and accurate evaluation of an individual's care and support needs.

Discharge to Assess would not change the thresholds of eligibility for CHC or support through the Care Act.

As a requirement to assess prior to discharge is removed the system of discharge notices, and associated financial penalties, will no longer be required and will also be removed by this legislation.

A standalone power for the Better Care Fund

As set out above, legislation will be amending the process for setting the NHS mandate so that it is no longer set on a rolling annual basis. Currently the allocation of the Better Care fund is tied to this annual process. As such, we will be creating a standalone legislative power to support the Better Care Fund and separate it from the mandate setting process.

This will be a technical change, and will not have any impact on the function, purpose or policy intention for the fund.

Proposals relating to Public Health

Alongside the Government's proposals for the future design of the public health system, we are bringing forward a range of targeted proposals in primary legislation relating to public health.

Taken together, the proposals in this Bill, alongside wider reforms including the creation of the National Institute for Health Protection (NIHP), aim to embed prevention and health improvement expertise, capacity and accountability within the NHS, and across local and national government. We will strengthen local public health systems, improve joint working on population health through ICSs, reinforce the role of local authorities as champions of health in local communities, expand the NHS's public health responsibilities, strengthen the role of the Department for Health and Social Care in health improvement, and drive more joint working across government on prevention.

We are also taking measures to intervene in one of the biggest health problems this country faces: obesity; recognising that there is an opportunity to help people make better informed food choices and to help them improve their own health.

Fluoride is a naturally occurring substance that has been shown to improve oral health. We will work to streamline the process for initiating proposals for new schemes for fluoridation of water in England by moving the responsibilities for doing so from local authorities to central Government.

Public Health power of direction

Under existing legislation in section 7A of the 2006 Act, the Secretary of State for Health and Social Care can make arrangements for his public health functions to be exercised by other bodies including NHS England.

Currently, this delegation is made by agreement by way of the 'NHS Public Health Functions Agreement' which is made annually between the Secretary of State and NHS England for commissioning a range of public health services, often referred to as 'section 7A services'.

Under this agreement, NHS England currently commissions a range of services which include national immunisation programmes; national population screening programmes; child health information services; public health services for adults and children in secure and detained settings in England; and sexual assault services (sexual assault referral centres).

The annual section 7A agreement process is seen as a helpful mechanism for collaborative working; adding value to the health service and providing a framework for delegating delivery of key programmes. However, it can present obstacles and limitations to public health by virtue of the requirement for an agreement by both parties to facilitate the delegation of a public health function from the Secretary of State.

Put simply, the Secretary of State cannot require NHS England to take the delegated function. This limits his options to deliver better care and value for patients and the taxpayer in a timely manner.

As such, our proposal is to create a power for the Secretary of State for Health and Social Care 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.

In common with the proposed powers of direction relating to NHS England, this includes scope to direct NHS bodies in how those functions are to be exercised.

This complements our proposals to enhance public confidence and accountability, and is part of a broader suite of changes to ensure the Secretary of State has an appropriate set of levers to enable him to play the role in the system that Parliament expects, restoring clearer democratic accountability to the NHS and removing potential obstacles to the delivery of public health functions.

The additional certainty and clarity of a power to make directions is desirable, for example, where the need for speed precludes protracted negotiations, or requires decisive resolution of a disagreement.

During the pandemic we have seen the increased need to ensure join up between our NHS and public health sectors. By having this power, we will enhance the ability to facilitate urgent updates or rapid service change when needed.

Obesity

Obesity is one of the biggest health problems this country faces. The number of children admitted to hospital for obesity and related conditions has quadrupled in the last decade.

Individuals who are obese in their early years are more likely to become obese adults, putting them at a higher risk of ill-health, such as heart disease, type 2 diabetes, several types of cancer and fatty liver disease, and premature death.

Evidence also shows that people living with obesity are significantly more likely to become seriously ill and be admitted to intensive care with Covid-19 compared to those with a healthy weight. The need to act now and tackle obesity is clear.

Building on the Government's obesity strategy, Tackling obesity: empowering adults and children to live healthier lives, we want to help people make better informed food choices and to help them improve their own health.

We are making several changes to legislation to support the Government's ambitions to halve childhood obesity by 2030, to reduce the number of adults living with obesity and to reduce health inequalities.

We are proposing to amend section 16 of the Food Safety Act 1990 to give Ministers the power to amend the EU Food Information to Consumers (2011/1169) regulations that have been transposed into UK law.

This will allow Ministers to amend these regulations following consultation with Parliament, thereby allowing Parliament to scrutinise and introduce new strengthened labelling requirements that best meet the needs of the consumer to make more informed, healthier choices.

This power will also enable the introduction of key obesity strategy policies such as changes to our front-of-pack nutrition labelling scheme and mandatory alcohol calorie labelling, following consultation.

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.

In November and December 2020, we consulted on how to go further and implement an online restriction for HFSS advertisements.

Depending on the outcome of this consultation, it is our intention to take forward further online advertising restrictions in this legislation.

Water Fluoridation

Water Fluoridation is clinically proven to improve oral health and reduce oral health inequalities.

It has a protective effect which reduces the impact of a high sugar diet or poor oral hygiene. Around 10% of the population of England currently receive fluoridated water. In the most deprived areas fluoridation of water has been shown to reduce tooth decay in 5-year olds by a third.

Since 2013, Local Authorities have had the power to propose, and consult on, new fluoridation schemes, variations to existing schemes, and to terminate existing schemes.

The Secretary of State for Health and Social Care has responsibility for approving any proposals submitted by local authorities.Local

authorities have reported several difficulties with this process including the fact that local authority boundaries are not coterminous with water flows which requires the involvement of several authorities in these schemes, in a way which is complex and burdensome.

In addition, local authorities are responsible for the oversight of revenue and costs associated with new proposals, including feasibility studies and consultations, while having no direct financial benefit from any gains in oral health.

In light of these challenges, we are proposing to give Secretary of State for Health and Social Care the power to directly introduce, vary or terminate water fluoridation schemes.

The Secretary of State for Health and Social Care already has the existing power to decide on whether proposals for water fluoridation should be approved and responsibility for the administration of schemes.

This removes the burden from local authorities and will allow the Department of Health and Social Care to streamline processes and take responsibility for proposing any new fluoridation schemes, which will continue to be subject to public consultation. Central Government will also become responsible for the associated work, such as the cost of consultations, feasibility studies, and the capital and revenue costs associated with any new and existing schemes.

As is the case now, once a scheme is agreed, the agreement's held with the water companies, will continue to be held centrally.

Reciprocal healthcare agreements with Rest of World countries

The UK has multiple reciprocal healthcare agreements with countries outside the EEA and Switzerland ('Rest of World countries'), such as Australia and New Zealand. However, without financial reimbursement or data sharing mechanisms, these agreements are limited in scope and reach.

In line with the Government's Global Britain strategy, looking to invest and strengthen the UK's relationships with countries across the globe and strengthen international healthcare cooperation, the 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. This would offer the opportunity to strengthen existing agreements with Rest of World countries and agree new reciprocal healthcare arrangements with Rest of World countries of strategic importance.

Comprehensive reciprocal healthcare agreements with Rest of World countries could 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 a premium for travel insurance or face difficulties in getting comprehensive insurance cover. They can also foster closer collaboration on healthcare with our international partners, supporting improved health outcomes for all.

In addition to supporting people access necessary healthcare, the proposed legislation will enable other advantages for agreements with Rest of World countries:

- The introduction of a reimbursement mechanism means that healthcare costs could be covered, so that no healthcare system will be left worse-off.
- The exchange of data between countries for the purposes of reimbursement will allow for constant monitoring and evaluation of the cost-effectiveness of these agreements over time.
- 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.

The scope for any new agreements will be agreed across relevant Government Departments and will be tailored to meet our national interest with input from the Devolved Administrations as well as relevant operational partners.

Proposals relating to safety and quality

The Government recognises that any health and care reforms must have safety and quality at their core. Legislative changes to wider structures should enhance and support improvements in these areas.

The government is therefore proposing to take the opportunity of legislation to bring forward

a range of proposals to support and enhance safety and quality in the provision of healthcare services.

The quality and safety measures in the Bill are about transparency and accountability to the public and patient.

They build on work of recent years that now needs urgent legislative underpinning to ensure this openness and accountability is embedded into the structure and culture of the NHS via the establishment of an independent Health Service Safety Investigations Body.

This will be complemented by proposals on professional regulation, which seek powers to make it easier to ensure that professions protected in law are the right ones and that the level of regulatory oversight is proportionate to the risks to the public, now and in the future.

We are introducing a medical examiner system for the purpose of scrutinising all deaths which do not involve a coroner.

This will improve the accuracy of cause of death and mortality statistics; increase transparency for the bereaved; and help deter criminal activity and poor practice.

We are also proposing to allow the MHRA to develop and maintain publicly funded and operated medicine registries and to work with the NHS to populate and maintain them where there is a clear patient safety or other important clinical interest.

Taken together this much needed package of improvements will bolster safety and quality in the NHS, ensuring that patients can have confidence that the care they receive is of the highest quality; that the professions they receive it from are regulated well; that all deaths are scrutinised in as transparent a manner as possible; and that we have the best data available about the medicines they are prescribed.

Health Service Safety Investigations Body

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

Our provisions propose the establishment of 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.

Independence as a concept is fundamentally important to HSSIB as it will be a crucial way of ensuring that patients, families and staff have trust in its processes and judgements. Investigation reports will make recommendations and require organisations to publicly respond to these measures, within a specified timescale.

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' whereby participants can provide information to the HSSIB for the purposes of an investigation in confidence and therefore feel able to speak openly and candidly with the HSSIB.
- encourage the spread of a culture of learning within the NHS through promoting better standards for local investigations and improving their quality and effectiveness. To this end the HSSIB will provide advice, guidance and training to organisations.

The Health Service Safety Investigations Body (the HSSIB) will continue the work of the Healthcare Safety Investigations Branch (HSIB) which became operational in April 2017 as part of NHS Improvement, to conduct high-level investigations into patient safety incidents in the NHS.

We are responding to concerns raised during the HSSI Bill's first Parliamentary Passage and plan to amend the Bill provision to extend HSSIB's remit to cover healthcare provided in and by the independent sector.

In addition, we are also introducing a power to enable the Secretary of State for Health and Social Care to require the HSSIB to carry out certain investigations into particular qualifying incidents or groups of qualifying incidents. We will also be including a regulation-making power allowing Secretary of State to set out

additional circumstances when the prohibition on disclosure (safe space) does not apply.

The Devolved Administrations have previously been involved in policy discussions prior to introduction in October 2019, and we will continue to engage with them on any proposed amendments as this work progresses further.

Professional regulation

The UK model of professional regulation for healthcare professionals has become increasingly rigid, complex and needs to change to better protect patients, support the provision of health services, and help the workforce better meet current and future challenges.

This proposal is seeking powers to make it easier to ensure that professions protected in law are the right ones and that the level of regulatory oversight is proportionate to the risks to the public, now and in the future. The powers in this proposal 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 reform programme is being taken forward on a four-country basis and we are continuing to engage with the devolved administrations as we take this work forward.

At present, section 60 of the Health Act 1999 provides powers to make a large number of changes to the professional regulatory landscape through secondary legislation. Our proposal for additional powers will widen the scope of section 60 and enable the Secretary of State for Health and Social Care 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.

The proposal includes:

(i) the power to remove a profession from regulation
Statutory regulation should only be used where it is necessary for public protection. The level of regulatory oversight for each profession should be proportionate to the activity carried out and the risks to patients, service users and the public.

The landscape of the health and social care workforce is not static, and risks will change over time as practices, technology and roles develop.

While statutory regulation may be necessary now for a certain profession, over time the risk profile may change, such that statutory regulation is no longer necessary.

A provision to enable the removal of a profession from statutory regulation through secondary legislation will make it easier to ensure that the protections and regulatory barriers that are in place remain proportionate for all health and care professions.

(ii) the power to abolish an individual health and care professional regulator

There is an inevitable duplication in having nine regulatory bodies (10 including Social Work England) performing similar functions in relation to different professions.

A reduction in the number of regulators would deliver public protection in a more consistent way, while also delivering financial and efficiency savings. Powers under section 60 already allow for the creation of a new regulators through secondary legislation.

However, it is not possible to use these powers to close a regulator.

This change would allow the Secretary of State to exercise this power and enable Parliament to abolish a regulator using secondary legislation, where its regulatory functions have been merged into or subsumed by another body or bodies, or where the professions that it regulates are removed from regulation.

Reducing the number of regulators is consistent with proposals set out in the July 2019 Government response to the Promoting professionalism, reforming regulation consultation.

The Secretary of State for Health and Social Care committed to reviewing the number of health and care professional regulators in the November 2020 Busting Bureaucracy policy paper.

(iii) The power to remove restrictions regarding the power to delegate functions through legislation

Regulators are currently restricted from delegating to another body some of their core functions.

This includes the keeping of a register of persons permitted to practise; determining standards of education and training for admission to practice; giving advice about standards of conduct and performance; and administering procedures relating to misconduct and unfitness to practise.

The removal of these restrictions would enable a single regulator to take on the role of providing a function across some or all regulators.

This will help to deliver public protection in a more consistent fashion and may also increase efficiency. Where a function is delegated, a regulator would retain responsibility for that function.

(iv) The power to extend the scope of section 60 to include senior NHS managers and leaders

Expanding the definition of professions covered by Section 60 to include senior managers and leaders and other groups of worker would enable us to extend regulation to those groups in the future.

The 2019 Kark Review of the fit and proper persons test recommended putting in place stronger measures to ensure that NHS senior managers and leaders have the right skills, behaviours and competencies and that those who are unsuitable to work in such roles are unable to do so.

However, the Kark review stopped short of recommending full statutory regulation and NHS England is currently considering how best to achieve this through non-statutory means.

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 Kark Review.

Medical examiners

Previously included in the above mentioned HSSI Bill, with this proposal we plan to amend 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. We support the recommendations of a number of inquiries, including the Shipman Inquiry, to create a new rigorous and unified system of death certification in England.

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

Once in place, we want to ensure that every death in England and Wales is scrutinised, either by a coroner or a medical examiner.

The medical examiner system will improve the accuracy of the cause of death and subsequently mortality statistics and will increase transparency for the bereaved and help deter criminal activity and poor practice.

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

Medicines registries can consolidate prescribing data for specific medicines with data from clinical care and other social administrative databases and can be further developed to capture more detailed and bespoke data on the cohorts of patients receiving these medicines. The data captured in a specific medicine registry can help support the safe use of the medicine.

The aim is to enable the establishment and operation of a comprehensive medicine information system, including data collection from private providers, which will support UK wide medicine registries. Medicine registries have the potential to be an important tool to support improving post-market surveillance of the use of medicines and help ensure consistent implementation of the highest standards of care.

This proposal will allow the MHRA to develop and maintain publicly funded and operated medicine registries so that we can provide patients and their prescribers, as well as regulators and the NHS, with the evidence they need to make evidence-based decisions.

The MHRA can already request for marketing authorisation holders (for example, a pharmaceutical firm which sells a medicine in the UK) to capture data to address specific gaps in knowledge regarding the use, safety and effectiveness of medicines.

However, the registries created and controlled by marketing authorisation holders have not always delivered the required evidence in reasonable time frames.

There is an opportunity to capitalise on the increasing volume of data routinely captured and linked across the healthcare system to build high quality sustainable registries that can deliver for all patients. These legislative changes will allow the MHRA to set up registries themselves, and work with NHS to populate and maintain them where there is a clear patient safety or other important clinical interest. Registries would be established for a medicine where the public need is clear and the benefits of a publicly held national registry that can access routinely collected data where it is available are required.

For example, where we know risks of a medicine can result in serious adverse health outcomes and consistent adherence to risk minimisation measures is critical, or where there are substantive unknowns about the safety or effectiveness of a medicine in a population and urgent evidence is required to support safe access to it.

Where a safety issue has led to the introduction of measures to minimise risk to patients, statutory registries with mandated inclusion of data will facilitate the early identification and investigation of potential non-compliance so that additional action can be taken by regulators in conjunction with health service providers at a national, local, or individual patient level.

Registries will help understand the impact of changes in risk minimisation measures on the health of patients and help us to understand how to ensure regulatory actions taken to support patient safety and clinical effectiveness are as effective as possible.

Registries will also provide an opportunity for patients to actively contribute information on their experiences with specific medicines bringing focus to the safety and clinical effectiveness issues that impact most on their lives.

Hospital food standards

The Independent Review of NHS Hospital Food published on the 26th October 2020 recommended ambitious NHS food and drink standards for patients, staff and visitors to be put on a statutory footing. We support this recommendation and believe that putting hospital food standards on a statutory footing will deliver for the first time, mandatory minimum standards for the provision of good hydration and nutrition in the NHS.

Adopting statutory standards would provide NHS hospital staff with access to healthier options and instil greater confidence in the public that the NHS will deliver appropriate levels of nutrition and hydration, as well as good quality food from all sources. This will also ensure standards are brought in line with the latest scientific diet and nutrition advice.

We propose to grant the Secretary of State for Health and Social Care powers to adopt secondary legislation that will implement the national standards for food across the NHS.

Annex B: Integration, partnerships and accountability

Working together

1. Healthy, fulfilled, independent and longer lives for the people of England will require health and care services, local government, NHS bodies, and others to work ever more closely together. Different professions, organisations, services and sectors will work with common purpose and in partnership. This will be especially important when we seek to focus on the people and communities that are most in need of support.

2. In many ways, the professionals are ahead of the organisations- multi-disciplinary working has been a recognised part of good care for many years now. But the organisations are catching up. We have seen real advances in recent years in forms of joint working, with a great deal of commitment in parts of local government and the NHS to developing broadly-based ‘integrated care

systems', many of which are now starting to make a real difference.

3. One of the most impressive and heartening features of the work to develop integrated care systems has been the emphasis on shared purpose over structures and titles. We are very mindful that any statutory framework for integrated care should preserve, spread and enhance this feature. The point was summed up with great clarity in the recent consultation on integrated care issued by NHS

England which set out the following four purposes:

a. Improving population health and healthcare;
b. Tackling unequal outcomes and access;
c. Enhancing productivity and value for money; and
d. Helping the NHS to support broader social and economic development.

4. These purposes provide both a formidable challenge and an excellent basis for collaborative working. Much of this work is happening at the level of 'place'.

The primacy of place

5. Many people who are making integration happen emphasise the importance of 'place' (which is most usually aligned with either CCG or local authority boundaries) in the joining up of services to support people to live well.

The most successful integrated care systems have often concentrated on developing the places within their wider geography to thrive and to find shared priorities to work on.

Many provider organisations and groupings of organisations such as primary care networks look to their 'place' as their primary focus.

6. Places vary by population, geography and they also vary in the history and strength of the connections between the key agencies that make joined up services and improvement to outcomes happen. It is vital that we recognise this as it gives us both assets and challenges: we must not damage the former in tackling the latter (as can happen when reform is attempted). This has led us – building on the experience of those making integrated care happen - to think hard about the right balance between what needs to be prescribed by legislation and other means and what should rightly be left to local and system level decisions.

Two forms of integration

7. The increased importance of integration within health and social care, is, of course, driven by the demographic imperatives of getting ahead of the curve on prevention and of supporting people with multiple health and care needs (especially in later life and especially in disadvantaged communities). It is also, as the third of the purposes set out by NHS England notes, about ensuring that we get the best possible value for money for the people we serve – the patients, service users and taxpayers of England.

8. As is described elsewhere in this paper, we intend to introduce legislation that removes the needless bureaucracy that has grown up around the commissioning and procurement framework for the NHS. This will allow the NHS to shift away from an adversarial and transactional system centred on contracting and activity payments to one that is far more collaborative and dedicated to tackling shared problems. While NHS provider organisations will retain their current structures and governance, they will be expected to work in close partnership with other providers and with commissioners or budget holders to improve outcomes and value. This is what the best organisations already do, and the work of early wave integrated care systems in recent years has shown how a collaborative approach can work well - even in a framework that was not designed to support it.

9. There are, then, two forms of integration which will be underpinned by the legislation: the integration within the NHS to remove some of the cumbersome boundaries to collaboration and to make working together an organising principle; and the integration between the NHS and other partners (principally local authorities) to deliver improved outcomes to health and wellbeing for local people.

10. **This adds complexity and will require thoughtful handling within systems with respect to governance and accountability; but we need both forms of integration if we are to achieve the improvements in outcomes that we seek. A more internally collaborative NHS will be a better, more coherent partner for local government and**

others. A wider partnership that includes local government and which enables a shift towards population health will deliver health, care and economic benefits and contribute to the levelling up agenda as well.

11. There is an important difference between the NHS and local government: each has a distinct line of accountability. Local government is, of course, held to account by local people and their elected representatives. NHS services and organisations are scrutinised by local authority overview and scrutiny committees and work with them closely on a number of issues – but their primary form of democratic accountability is (via NHS England) to national government and ultimately to Parliament. This will be important to recognise and reflect in the legislation but, as the vanguard ICSs have shown, it is no barrier to shared purpose, shared leadership and the pursuit of outcomes and service integration to improve the lives of local people.

The role of legislation

12. The purpose of legislation in this context is to create an enabling framework for local partners to either build upon existing partnerships at place and system levels or, where these partnerships are yet to form in earnest, to begin the work of aligning services and decision making in the interests of local people.

13. The three factors that frame our proposed approach are:

a. The importance of shared purpose within places and systems;
b. 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;
c. 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.

14. Legislation in this context needs to be used in a targeted way and in conjunction with a great deal of local and system level freedom to make arrangements that work for all partners. We will not, for example, be making any legislative provision about arrangements at place level.
15. [Subject to NHS England consultation work]. NHS England's November consultation on integrated care generated a large number of responses from individuals and key organisations.

It concluded [ADD FURTHER DETAIL LATER].

16. Having considered the response to the NHS England consultation, the Government has concluded that the allocative functions of CCGs should be held by a system level body responsible for integrated care

17. Many of the responses served to reinforce the importance of the key factors for framing legislation set out above. As the response from the King's Fund noted 'We also recognise that there is a careful balance to be struck between using legislation to clarify and improve accountability and transparency, while also creating the flexibilities to allow systems to develop the arrangements best suited to their local contexts and population needs. Difficult trade-offs will be involved in resolving some of the issues we have highlighted in this section and we do not underestimate the complex nature of the decisions involved in doing so'.

18. These considerations have led us to the following model:

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 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. We would expect the public name of each ICS NHS Body to reflect its geographical location – for example, NHS Nottinghamshire or NHS North West London.
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:

a. developing a plan to address the health needs of the system; and
b. Set out the strategic direction for the system and explain the plans for both capital and revenue spending for the NHS bodies in the system;

19. Discussions with a number of stakeholders including the Local Government Association has led us to the conclusion that 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. 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. 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.

20. 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). Our intention is to specify that an ICS should set up a Partnership and invite participants, but we 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.

21. 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. We will, working with NHSE and the LGA, also issue guidance to support ICSs in establishing these bodies. 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.

We know that this element of flexibility has been of value to the early wave ICSs where there are many (and different) examples of partnership boards and of arrangements at place level. In many cases, partnership boards have served as a way to identify, develop and drive shared priorities and projects between local government and NHS partners.

22. **Taken together, we think these arrangements provide the right balance between recognising the distinctive accountabilities and responsibilities of the NHS, Local Authorities and other partners while also strongly encouraging areas to go further in developing joint working and decision-making arrangements that deepen and improve over time in the interests of local people.**

Annex C: Stakeholders engaged by DHSC

Despite the unprecedented context under which we have developed this paper, we have still managed to engage with a range of stakeholders from across the health and care system, both through roundtables and smaller discussions.

We would like to extend our sincere thanks to the following organisations for discussing the themes and proposals at the centre of this paper with us.

- *Academy of Medical Royal Colleges*
- *Age UK & Care Support Alliance*
- *Alzheimer's Society*
- *Association of Directors of Adult Social Services (ADASS)*
- *Association of Directors of Public Health*
- *Association of Pharmacy Technicians*
- *British Medical Association*
- *Care England*
- *Care Providers Alliance*
- *Care Quality Commission*
- *Care UK*
- *Carers UK*
- *Centre for Ageing Better*
- *Centre for Mental Health*
- *Faculty of Public Health*
- *Health Education England*
- *Health Foundation*
- *Healthcare Safety Investigation Branch*
- *Healthwatch England*
- *Institute for Government*
- *International Longevity Centre UK*
- *Learning Disability England*
- *Local Government and Social Care Ombudsman*
- *Local Government Association*
- *National Association of Primary Care*
- *National Care Forum*
- *National Voices*
- *NHS Assembly*
- *NHS Blood and Transplant*
- *NHS Business Services Authority*
- *NHS Clinical Commissioners*
- *NHS Confederation*
- *NHS Digital*
- *NHS Employers*
- *NHS England*
- *NHS Improvement*
- *NHS Providers*
- *NHS Resolution*
- *National Institute for Health and Care Excellence*
- *Nuffield Trust*
- *Policy Exchange*
- *Public Health England*
- *Royal College of General Practitioners*
- *Royal College of Nursing*
- *Royal Pharmaceutical Society*
- *Social Care Institute for Excellence*
- *Skills for Care*
- *SOLACE*
- *The King's Fund*
- *The Patients Association*
- *Think Local Act Personal*
- *UK Home Care Association*
- *UNISON*