26 March 2021

Jeremy Hunt MP
Chair, Health and Social Care Committee

By email

Dear Jeremy

Inquiry into the white paper on health and social care

We were pleased to have the opportunity to raise a number of key issues relating to the government's white paper *Integration and Innovation: working together to improve health and social care for all* in our written evidence and in the committee evidence session on 2 March. We now write to follow up our oral evidence with five areas that we think are important for the committee to address in its inquiry report.

The committee is in a unique position to help ensure that the forthcoming Bill provides an enabling legislative framework that supports the health and care sector, and the providers we represent, to deliver high quality care for patients and service users. We therefore ask the committee, in formulating its conclusions and recommendations, to consider the following issues as a priority:

1. **The proposed new power of direction for the Secretary of State for Health and Social Care over the new merged NHS England must be framed in a way that maintains the NHS's clinical and operational independence.**

The government has not yet set out the detail of how it intends any new power of direction to operate. But you will remember that in our oral evidence we set out a number of areas where we, and our members, believe it would be inappropriate for the Secretary of State to have an unfettered power of direction.

We therefore hope the committee would make it clear that they believe that, however the power is framed, appropriate NHS clinical and operational independence must be maintained. For example, the power of direction should not be exercisable in respect of individual NHS procurement decisions, treatment or drug funding decisions, the

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hiring and firing of frontline NHS leaders, who should continue to be appointed openly and on merit, or geographical resource allocations.

The government would therefore need to appropriately define the power in terms of:

- its scope and the areas of decision making/activity where it might apply and, conversely, not apply
- the need for full and timely transparency when the power is exercised - we believe this should include the need for the Secretary of State to set out why their use of the power of direction, on each occasion, meets an objectively defined public interest test
- the need for appropriate consultation with affected parties before the power is exercised including, as part of the transparency arrangements, the publication of the views of the body being directed.

Given that the introduction of this power is a new policy proposal which has had no prior consultation, we also hope the committee would urge the government to discuss the drafting with the sector before finalising it.

NHS England, Monitor and the Trust Development Authority (TDA) each have a different statutory base with varying degrees of ministerial power of direction, from almost complete of control of the TDA to very little control of Monitor. In line with the argument above, we think it is important that the clauses creating the newly merged organisation similarly reflect the need for that organisation, and the wider NHS, to have an appropriate degree of independence. This needs to include the arrangements for the mandate of that organisation.

We recognise the logic of the Secretary of State having "Henry VIII type powers" to move responsibilities between arm's-length bodies via secondary legislation, However the exercise of these powers, again, must not threaten the operational independence of key parts of the NHS. We therefore hope the committee would endorse our view that it is inappropriate, given their central roles, for the Secretary of State to be able to either abolish the newly merged NHS England or Care Quality Commission, or neuter them by transferring the majority of their powers to other bodies, via secondary legislation. Such far reaching changes should require primary legislation.

2. Secretary of State's powers over local reconfigurations.

The white paper proposes a new power of intervention for the Secretary of State on local reconfigurations. Again, it is difficult to be definitive in advance of seeing the detailed drafting. But we would hope that the committee would express its support for the following principles:

- that any Secretary of State involvement should be fully transparent, with the right of the affected parties to make appropriate representation and the Secretary of State's intervention made against set, public, criteria

- that there is an appropriate role for an independent body like the Independent Reconfiguration Panel to provide independent advice on detailed issues including the validity and importance of the clinical case for change
- that there should be an appropriate threshold governing the level of reconfiguration where the Secretary of State is involved
- that, given the overwhelming importance of patient safety in these considerations, there should be an explicit test that use of the power must maintain or improve safety before the power can be exercised. As part of the exercise of the power, the providers and integrated care system (ICS) concerned, NHS England and the public should all be consulted on the relevant safety issues before the power can be exercised, with those views then made public.

Again, given that this is a new power that has been introduced without prior consultation, we hope the committee would urge the government to agree how the power would work with the sector before finalising the drafting.

3. For ICSs to function effectively, they need a sufficiently permissive legislative framework and clarity around how accountabilities fit together across health and care.

We support the move to place ICSs on a statutory footing but remain concerned about some of the detail here. We hope that the committee will stress:

- the importance of the legislation being enabling and permissive, to enable different systems to flexibly frame arrangements that best suit their local needs
- the need for ICS accountabilities to be defined in three ways:
    - to parliament, via the Department of Health and Social Care and NHS England
    - to local communities
    - to their component organisations, rather than just the first of these accountabilities.
- the need for ICS governance to reflect these three-way accountabilities
- the need for detailed work, via NHS England guidance, setting out how the accountabilities of ICSs will align with the accountabilities of trusts and foundation trusts. Given the level of risk, resource and complexity being managed by trusts, there must be absolute clarity on how the accountabilities of all the parts of a local health and care system fit together, without duplication, overlap or additional bureaucracy. This includes complete clarity on how financial flows will work and how any delegation to place based and provider collaborative arrangements would work.

4. The Bill needs to go further than simply set out how workforce accountabilities are distributed.

As we have discussed in several recent evidence sessions, the NHS is desperately lacking a regularly produced, long-term, workforce numbers plan setting out the desired future shape and size of the NHS workforce. While we welcome the duty on the Secretary of State to set out how workforce planning responsibilities are to be discharged, we believe this duty needs to be considerably strengthened.

We hope the committee would support the idea of an additional duty in the Bill to ensure the development of regular, public, annually updated, long term workforce projections drawing on input from all relevant NHS arm's-length bodies, NHS frontline organisations such as ICSs and trusts and expert bodies such as think tanks. We believe these projections should set out, independently from ministers, on an arm's-length basis, the size and shape of the future workforce needed to deliver safe, effective, high quality care and the estimated cost of delivering this workforce. There should then be a duty on the Secretary of State to regularly update parliament, more than once a parliament, on the government's strategy to deliver those long-term projections, including its approach to providing the required funding.

We would also like to see a new statutory duty to involve local systems and trusts in workforce planning, as the current proposal to abolish Local Education and Training Boards removes this important statutory obligation on Health Education England.

5. The proposed power on NHS Foundation Trusts' capital spending limits (CDEL) must reflect the precise wording of the 2019 proposals developed by NHSE/I and endorsed by this committee in its report on those proposals.

The white paper is clear that foundation trusts and trusts retain their current accountability for the delivery of safe care. The right amount of capital expenditure is central to this task. While we recognise the need, in the move to system working, for NHS England to have a reserve, backstop, power to set individual foundation trust capital spending limits, it is vital that use of this power is carefully controlled. NHS England's 2019 legislative proposals contained a series of detailed safeguards that were agreed with NHS Providers.

We are concerned that the white paper omitted many of these safeguards. These included a commitment for NHSE to explain why the use of the power in each case is necessary, describe what steps it had taken to avoid requiring its use, and publish any representation from the NHS foundation trust affected. These safeguards must be explicit.

We also hope that the committee could make clear that the problem of capital limits is, at heart, caused by insufficient overall levels of NHS capital.

We wanted to avoid a long 'shopping list' of priorities and have therefore highlighted the above areas as key priorities.

But we also remain concerned about the Secretary of State's proposed powers on turning safe space on and off and their proposed ability to direct the Health Service Safety Investigation Board to undertake investigations risk its much-needed independence. We are also clear that the Secretary of State should only create new trusts in a locality if this has the support of the relevant ICS and affected providers.

Please do get in touch with us if you would like to have a more detailed conversation on any of these issues.

Yours sincerely

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Annex 1: The NHS's recommendations to government and parliament for an NHS Bill, NHS England and NHS Improvement, September 2019

204. We are not proposing a general power to set capital limits on foundation trusts. Instead, we are proposing that the power for NHS Improvement to set annual capital spending limits for NHS foundation trusts should be circumscribed on the face of the Bill as a narrow 'reserve power'. Each use of the power should apply to a single named foundation trust individually, automatically cease at the end of the current financial year and the newly merged NHS England and NHS Improvement should (a) explain why it was necessary, (b) describe what steps it had taken to avoid requiring its use and also (c) include the response of the foundation trust. To ensure transparency the reasons would be published. To ensure transparency the reasons would be published. The precise form of publication will be a matter for the Bill drafting process. NHS Providers has stated its preference that publication should be in parliament.

205. We believe that this approach strikes the right balance. It avoids creating a general power to direct all foundation trusts on capital expenditure. The original intention was neither to erode foundation trust autonomy nor cut across the accountability of a foundation trust board. Nor was it to direct an foundation trust in relation to which individual capital investment decisions they could or could not make within an overall limit. This is now clear through the proposal for a highly circumscribed power.

206. The revised power provides an ultimate safeguard to the taxpayer in the event that an individual trust's actions threaten to breach national capital expenditure limits. This is an issue of equity as well as proper financial management - if one trust's actions breach the capital limit it means capital spending in another community has to be reined back to ensure the NHS as a whole lives within its allotted capital resources.