House of Commons General Committee on the Health and Care Bill
NHS Providers written evidence, October 2021

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS trusts and foundation trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate. NHS Providers has all trusts in voluntary membership, collectively accounting for £92bn of annual expenditure and employing more than one million staff.

Key points

- We welcome the direction of travel set out in the Health and Care Bill which aims to drive closer collaboration and integration across the health and social care sector, helping trusts to build healthier communities.
- While we welcome the move to system working, more clarity on how different parts of the health system will work together is needed. Allowing different systems flexibility in how they frame their arrangements to meet local needs will also be key.
- We are concerned that the legislation opens up the possibility of political interference in the health service by drawing significant powers of intervention and direction to the secretary of state. Maintaining the clinical and operational independence of the NHS is vital to ensuring this complex system can be run effectively.
- Similarly, we are concerned that new powers to allow the secretary of state to intervene in local service reconfigurations, as currently drafted, risk undermining local accountability in the NHS.
- We welcome measures in the Bill to place a new duty on the secretary of state setting out how workforce planning responsibilities are to be discharged but believe this duty needs to be strengthened.
- We strongly support the creation of the Health Services Safety Investigations Body (HSSIB) as an independent statutory entity. However, we are concerned with aspects of the Bill as currently drafted are liable to weaken the boundaries of safe space and the independence of HSSIB
- We are keen to ensure that the new provisions that will give the Care Quality Commission (CQC) scope to assess and rate systems, do not impact on their ability to provide independent assurance - in particular, the secretary of state's powers to set priorities and objectives for the CQC's assessments of Integrated Care Boards (ICBs). The existing arrangements, which require CQC to consult the secretary of state, have been successful in providing the necessary assurance so we do not feel there is a need to change what already works well.

Overview

1. The publication of the Health and Care Bill in July followed a set of proposals for legislative change originally brought forward by NHS England and NHS Improvement (NHSE/I) in autumn

2019. These were further developed in the *Integrating Care*[1] consultation with regard to system working and, most recently, in the Department of Health and Social Care's (DHSC's) *Integration and innovation* white paper[2] published in February 2021.

2. We support the direction of travel and the opportunity the Bill presents to design the right system architecture that will deliver sustainable, high-quality care for the future. However, we believe there are a number of improvements that can be made which will make this the transformative piece of legislation the government wants it to be.

NHS England

3. Clause 3 (NHS England mandate) removes the current requirement for a mandate to be set before the start of each financial year. Instead, a mandate can be set at any time and remain in force until is it replaced by a new mandate. The statutory link between the mandate and the annual financial cycle will be removed and the Bill proposes that NHS England's annual limits on capital and revenue resource be given statutory force through the financial directions.

4. We understand the logic to creating the potential for a longer running and more strategic mandate. However, there is also a need to maintain the link between the 'asks' of the NHS and the resourcing envelope available and to avoid a situation where priorities could change within a year (or any timeframe), and potentially be unfunded. These proposals will remove the duty to set NHS England's capital and revenue resource limits in the mandate itself. Instead, these limits will be set within the annual financial directions that are routinely published, and which will in future also be laid in parliament. There is a risk that disconnecting the mandate from financial planning could lead to inadequate funding, leaving the NHS unable to deliver on government priorities.

Integrated Care Systems

5. One of the key elements of the Bill is the focus on developing system working, with integrated care systems (ICSs) to be placed on a statutory footing. We support the government's ambition to embed the success of collaboration and are keen to see an enabling, flexible legislative framework that accelerates the current direction of system working.

6. The Bill should be enabling and permissive in order to allow different systems flexibility in how they frame their arrangements to meet local needs. This can be achieved by defining the accountabilities of ICBs in three ways: firstly, to Parliament, via the Department of Health and Social Care and NHS England; secondly, to local communities; and thirdly, to their component organisations. At the moment, accountabilities are framed around only the first of these.

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[1] NHS England, *Integrating care: Next steps to building strong and effective integrated care systems across England*, (https://www.england.nhs.uk/publication/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems-across-england/), November 2020.

[2] Department of Health and Social Care, *Integration and innovation: working together to improve health and social care for all,* (https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all), February 2020

Expanding these to incorporate all three will ground ICBs in their communities and keep their focus on serving patients and service users.

7. Moreover, while we support the move to put ICBs on a statutory footing, we are still unclear how the relationships of local bodies fit together and align. For example, trust leaders and their system partners are considering how an Integrated Care Partnership (ICP) and an ICB will work together and with place, providers collaboratives, and constituent organisations to effectively deliver system ambitions. While the minister indicated during committee discussions that he expects few disagreements between system partners, constructive challenge is an important part of good governance as it helps to ensure robust decision making. The implications of this need to be more fully considered.

8. The accountability of ICB chairs locally is important and speaks to the purpose of the closer integration of health and care and the ability of local systems to best serve the needs of their communities. While we welcome the minister's reassurance that there will be guidance on how NHS England could remove the chair and what the thresholds will be, we continue to be concerned that ICB chairs only seem to be answerable to the secretary of state.

9. We are concerned about a lack of clarity in the legal duties, roles and responsibilities across the health and care system, including those of NHS England and the secretary of state. Given the nature and degree of power over ICBs and individual organisations that could be exerted under the Bill's proposals, it is essential to address these issues. Otherwise there is a risk of unclear accountabilities, confusion, stasis and duplication – and in turn, the potential for costly and time consuming judicial review proceedings.

10. It is essential to ensure the views of the full range of provider types are heard as part of the ICB decision-making process. This parity in decision-making is critical if we are to implement the collaborative approach to planning and delivering more integrated care, as intended. However, there is a tension here between a fully inclusive approach and the need for a streamlined board which allows for effective decision-making. We are therefore not arguing for specific legal provisions for each segment of the provider sector to be represented on the board of the ICB, but we have called for each to have a robust mechanism for providers to feed into and influence ICB decision-making. The model constitution states that ICBs should ensure there are mechanisms for including the full range of perspectives through its decision-making model and structures.

11. It is vital to make crystal clear the status of the relationship between trusts and ICBs, and how the statutory accountabilities of trusts, foundation trusts and ICBs align. There also needs to be clarity within the legislation on how the roles and responsibilities of the current NHSE/I regions, ICBs, ICPs, trusts, foundation trusts, health and wellbeing boards (HWBs), places, provider collaboratives, neighbourhoods and primary care networks (PCNs) will all fit together. To address this, we believe that the Bill needs to include the following:

a. A requirement to consult all trusts and foundation trusts within the ICB area (as well as primary care and local authorities) in developing the ICB composition and constitution, and in any proposed change to ICB boundaries;
b. Provision for a challenge mechanism for trusts and foundation trusts to raise concerns to NHS England about the ICB composition, constitution and plans if necessary/in extremis;
c. Safeguards around the power for NHS England to intervene directly in how ICBs exercise their functions, in particular setting out how ICB failure, or being at risk of failure, will be defined, assessed and determined; and
d. Clarity on how organisations will discharge their legal duties where there is potential for overlap (for example, ICBs will have a role in quality improvement – how does this align with providers' responsibilities for the care they provide.

Care Quality Commission reviews of integrated care systems

12. We are broadly supportive of these provisions as they provide the mechanism for ICSs to be held accountable for the decisions they make that affect the quality and safety of care within their geographical footprint. Recognising that NHS trusts do not operate in a vacuum, it is important to understand the link between leadership and decision making at system level and the quality of care being delivered at an organisational level.

13. These provisions, including accountability of the CQC to the secretary of state, broadly mirror existing arrangements, but there are areas which could impact on the CQC's ability to provide independent assurance. In particular, the secretary of state's powers to set priorities and objectives for the CQC's assessments of ICBs could risk creating a regulatory system that is overly focused on national priorities rather than local population needs. The existing arrangements, which require CQC to consult the secretary of state, have been successful in providing the necessary assurance so we do not feel there is a need to change what already works well.

14. We would welcome clarification on what the CQC will be expected to review and assess at system level. For example, assessing outcomes at system level would be challenging, as where they are impacted by the quality and safety of care, these issues would manifest at the level of the registered service provider. There is also a risk that measuring outcomes, quality or safety of ICSs could result in duplication with assessments also being carried out at the provider level, which should be avoided. While we agree with the minister's statements in committee, that the experience and outcomes of people who use health and care services should be central to these reviews, assessing experiences will be challenging at this level given the geographical scale and interactions across a system. A focus on an ICSs' engagement with different communities within its wide-ranging footprint may be a more effective approach. There may also be challenges regarding assessing the strength of relationships across an ICS and determining how this directly impacts on the quality of care across a whole system.

15. The minister provided some welcome clarity on the expected audience for a CQC system-level assessment, stating that the CQC will have to ensure that the public will have access to the information about the provision of care in their area. The minister also stated that they expect the system partners will want to develop actions in response to these reports. It is still unclear however how an assessment at system level would add value for a patient or service user, given it is registered service providers that deliver the care to them directly.

16. The provision is helpfully permissive in how the CQC is to conduct its reviews and assessments, which we hope will enable the CQC to evolve its approach as ICSs become more established. It is clear that the CQC will need to consult with NHS England before it prepares or revises the statement which sets out the frequency with which reviews are to be conducted and the period to which they are to relate. Alignment with NHS England, in particular its system oversight framework, is vital to reducing any risk of duplication in assessments. We believe ICBs, NHS trusts and foundation trusts, and system partners must also be consulted on any revisions to the CQC's statement. Given the challenges of assessing quality at system level, it is also important that NHS trusts and systems have a right of reply to ensure the right checks and balances are in place.

Integrated care systems: financial controls

17. Under the current financial regime, important checks and balances are enshrined in law. The Bill proposes a series of changes to financial flows (contract and payment mechanisms) that symbolise a cumulative loss of independent oversight, including:

    a. the replacement of the national tariff with a new NHS payment scheme, representing a move away from mandatory national prices for many services to commissioners having more flexibility over the prices they pay providers;

    b. the formal merger of NHS England and NHS Improvement, meaning there will be no process of negotiation between two 'parties' embedded in the development of the NHS payment scheme (unlike the development of the tariff); and

    c. the removal of an independent review mechanism to deal with objections to the NHS payment scheme, currently delivered by the Competition Markets Authority (CMA) as part of the statutory objection process for the tariff.

18. Clause 23 of the Bill (Financial responsibilities of integrated care boards and their partners) proposes that each ICB, and its 'partner NHS trusts and NHS foundation trusts', will be collectively required to deliver financial balance and seek to achieve financial objectives set by NHS England. A separate power will allow NHS England to set additional and mandatory financial objectives specifically for trusts. This builds on the existing duties placed on clinical commissioning groups (CCGs) and trusts under the Health and Social Care Act 2012 and NHS Act 2006 respectively.

19. We support the intention of these proposals, which is to facilitate greater integration in healthcare and, in doing so, help each ICS deliver on its core purpose to improve outcomes,

tackle inequalities, enhance productivity, and drive broader social and economic development. We expect the new financial regime to run smoothly in the vast majority of cases. However, in the extreme event that an ICB, trust or foundation trust feels it has been given an impossible task – for example, if its funding envelope is insufficient to meet patients' needs, potentially putting outcomes, quality of care and patient safety at risk – it is important that clear routes to recourse and challenge exist. Given the challenging funding situation expected in 2022/23 and 2024/25, we believe that putting these clear routes of recourse and challenge will be vital and would urge the government to look at this issue in more detail.

20. As currently drafted, there is no objection mechanism in clause 23 (Financial duties of integrated care boards: use of resources), despite there being a clear link between the funding available to a provider and its ability to deliver safe care. We therefore support the addition of a route of recourse when an ICB, trust or foundation trust considers that its capital resource limit or revenue resource limit risks compromising the safety of patients and believe that an objection mechanism should be added to Bill.

21. We acknowledge that during the public bill committee proceedings the minister addressed what action could be taken if unexpected funding needs arise, explaining that DHSC can issue funding to NHS trusts and foundation trusts to enable them to continue operating safely. Although we welcome the minister's reference to ensuring emergency funding would be available in certain circumstances, preventing the need for such funding in the first place would be favourable and important to securing the best value from the NHS' allocations.

Merger of NHS bodies etc

22. We are concerned that the formal merger of NHSE/I, together with the abolition of Monitor and the Trust Development Authority (TDA), will create a risk of conflicts of interest between the regulatory function of Monitor and NHS Improvement and the transformation and commissioning functions of NHS England.

23. Clause 27 (Exercise by NHS England of new regulatory functions) of the Bill requires NHS England to minimise conflicts of interest in the exercise of its new regulatory functions and to manage those conflicts that may arise. However, this does not necessarily remove the eventuality that NHS England would be required to oversee and regulate the outcome of decisions it has made. The current wording in clause 27 requires NHS England to 'minimise' and 'manage' conflicts of interest. This does not remove the inherent clash of responsibilities. We would recommend adding stronger safeguards on the face of the Bill which would require NHS England to 'avoid' conflicts of interest.

Secretary of state's functions

24. While we welcome Clause 33 (Report on assessing and meeting workforce needs) which will place a new 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 and support adding the following duties to the Bill:

a. A duty to develop regular, public, biennially updated, long term workforce projections;

b. A duty on the secretary of state to regularly update parliament on the government's strategy to deliver long-term projections; and

c. A new statutory duty to involve local systems and trusts in workforce planning (NHS England and HEE must consult with health and care employers, providers, trade unions, royal colleges, etc when assisting the secretary of state in producing the biennial workforce report).

25. We support the position set out by a broad coalition of organisations[3] which calls for the secretary of state to publish, every two years, independently verified assessments of current and future workforce numbers consistent with the Office for Budget Responsibility (OBR) long-term fiscal projections.

Powers of Direction

26. Clause 37 of the Bill (General power to direct NHS England), as currently drafted, appears to open up the possibility of ministers' involvement in aspects of the operational management of the health service. We are concerned that without appropriate safeguards in place, decisions might be reached based on political motivation rather than focused on the best interests of services and populations.

27. Clinical and operational independence must be maintained in order to ensure equity for patients within the service; the best use of constrained funding; and clinical leadership with regard to prioritisation and patient care. While the intention may be to deploy these powers on rare occasions, the potential impact is so great that safeguards must be put in place. We welcome the decision to add a duty to publish a direction but believe additional safeguards are needed to protect the NHS's independence by defining the power in terms of:

    a. The publication of guidance defining an objective "public interest" test, its scope and the areas of decision making and activity where it might apply and, conversely, not apply. As drafted, the language is subjective and unclear. In line with the use of this test in other regulatory settings, there should be clear, proportionate and necessary criteria before the power is exercised.

    b. 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 before giving a direction.

    c. 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.

[3] Coalition amendment briefing on Clause 33 (Report on assessing and meeting workforce needs), (https://www.rcplondon.ac.uk/file/32501/download), September 2021

28. A lack of safeguards could arguably expose the government, any secretary of state, the service, and patient care to undue, unmanaged risk. We believe there needs to be further discussion about whether such broad powers are necessary and proportionate. We believe that any direction given by the secretary of state should be in the public good, its impact should be understood, and such impacts should be reviewed so that adverse effects can be rectified.

29. We recognise the logic of the secretary of state having powers to move responsibilities between arm's-length bodies via secondary legislation as set out in Part 3 of the Bill. However, the exercise of these powers must not threaten the operational independence of key parts of the NHS. Of particular note is the power which would allow the secretary of state to transfer functions between bodies. The power to abolish a body such as the Human Fertilisation and Embryology Authority, or the power to transfer the majority of its powers to other bodies, requires proper parliamentary scrutiny. We believe that such moves should require primary legislation.

Reconfiguration

30. Clause 38 (Reconfiguration of services: intervention powers) gives the secretary of state intervention powers in relation to the reconfiguration of NHS services. As currently drafted, this gives wide ranging powers to the secretary of state to direct local service reconfigurations, and does so without appropriate safeguards.

31. Decisions on local service reconfigurations are best taken locally by the organisations that are accountable for those services following meaningful engagement with local communities. While clarity and speed can be welcome in making such decisions, this should not be at the expense of local engagement and decision-making.

32. The proposed powers risk undermining local accountability in the NHS, and local authority overview and scrutiny committees. They do not necessarily protect the best interests of patients and run the risk of political interference in the provision of local NHS services. In order to ensure that this power does not adversely affect services and patient care, we believe that the following principles should be applied and set out on the face the Bill:

    a. 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;

    b. 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;

    c. There should be a serious and substantial threshold governing the level of reconfiguration where the secretary of state is involved; and

    d. There should be an explicit test that use of the power must maintain or improve safety before it can be exercised.

NHS Foundation Trusts: Capital spending limits for NHS foundation trusts

33. The Bill puts forward clause 52 (Capital spending limits for NHS trusts) which gives a new power to NHS England to restrict the spending of any individual NHS foundation trust in the same way that expenditure by an NHS trust can already be limited. The power is not intended to be a general power used to set capital expenditure limits for all foundation trusts, nor direct a financial trust in relation to individual capital investment decisions. This proposal arises from the need for DHSC and NHS England to ensure that the national capital expenditure limit cannot be breached.

34. We must be mindful that this proposal does not address the root cause of the problem at hand which is prolonged underinvestment in the NHS estate and technologies, and the need for a national capital expenditure limit that fairly reflects the NHS' investment needs. Despite recent welcome injections of funding, the capital maintenance backlog now stands at £9.2bn. Half of this is considered a 'high' or 'significant' risk to patients and staff. We are therefore continuing to call for recent increases to the NHS' capital budget to be sustained in future years and be distributed fairly across the provider sector.[4] Ultimately, a limit on foundation trusts' capital expenditure is not going to improve patient safety, operational performance, efficiency, nor the services' ability to transform and modernise care.

35. While we recognise the need, in the move to system working and the overall national constraints on capital spending, for NHS England to have a reserve, backstop, power to set individual foundation trusts capital spending limits, it is vital that use of any such power on foundation trust capital investment is carefully controlled. It is absolutely right that foundation trusts and trusts retain their current accountability for the delivery of safe care and having sufficient freedom over capital expenditure is central to this task.

36. The current drafting does not mirror NHSE/I's September 2019 legislative proposal which was the result of detailed negotiations with NHS Providers on behalf of our foundation trust members. This clause also cuts across the Health and Social Care Committee's unequivocal position that the power to set capital spending limits for foundation trusts "should be used only as a last resort".[5] NHS England's 2019 legislative proposals contained a series of detailed safeguards that we consider essential to see in the Bill. These are:

    a. The power to set capital spending limits for foundation trusts is circumscribed on the face of the Bill as a narrow reserve power;
    b. Each use of the power should apply to a single named foundation trusts individually;
    c. Each foundation trust's capital spending limit should automatically cease at the end of the current financial year;

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[4] NHS Providers, *Rebuilding our NHS – The case for capital funding*, (https://nhsproviders.org/media/692149/rebuilding-our-nhs.pdf), September 2021.

[5] Health and Social Care Committee, *NHS long-term plan: legislative proposals* (https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/2000/2000.pdf), 18 June 2019.

d. NHSE/I is required to explain why use of the power was necessary, describing what steps it has taken to avoid requiring its use and include the response of the foundation trust when publishing each order; and
e. There is a requirement for each order to be published in parliament, to ensure maximum transparency

37. While we understand that accompanying guidance will be published outlining the circumstances under which NHS England is likely to make an order, and the method it will use to determine the capital spending limit, this is no substitute for including adequate protections in the Bill. We therefore have significant concerns about clause 52.

Health Services Safety Investigations Body

38. We strongly support the principle of creating HSSIB as an independent statutory entity and enabling it to conduct safe space investigations so that the NHS can improve patient care and learn when things go wrong. Organisational cultures that support staff to speak up have higher levels of staff engagement and patient satisfaction and are associated with reduced errors in care and better safety. In 2019, the Health Service Safety Investigations Bill was published but did not progress through parliament. We are pleased to see a number of helpful revisions to those earlier provisions, but we want to ensure that these provisions genuinely enable HSSIB's independence – crucial to its ability to carry out its intended systemic safety role – and protect the integrity of safe space.

39. The parliamentary joint committee on the Draft Health Service Safety Investigations Bill in 2018 made clear the importance of HSSIB's independence of judgement in deciding what investigations it undertakes. If the secretary of state is to be able to direct the HSSIB to carry out an investigation, then three explicit balancing provisions are needed to maintain the HSSIB's independence. Firstly, it must be able to decline to carry out the investigation where there is reasonable justification. Secondly, adequate funding must be made available to the HSSIB to enable it to carry out such investigations in order to avoid compromising its ability to carry out its investigative function as the HSSIB would otherwise determine. Thirdly, the continuing independence of the HSSIB in how it carries out any such investigation and the independence of its consequent recommendations is paramount and should be explicitly protected.

40. We are also concerned that the exceptions on prohibition of disclosure of protected materials are wide ranging and unreasonably open to external applications for access. The impact assessment published for the previous HSSI Bill in 2019 noted that, "Litigation in healthcare is a more frequent occurrence than in other areas of accident investigation. It is therefore possible that lawyers representing patients or NHS staff involved in safety incidents that have been investigated by HSSIB, may make applications for disclosure of 'safe space' information hoping to uncover material of benefit to their clients".[6] The High Court's balancing test seems liable to

[6] Department of Health and Social Care, *Health Service Safety Investigations Body (HSSIB) Impact Assessment No 3136* (https://publications.parliament.uk/pa/bills/lbill/2019-2020/0004/20004-IA.pdf), 16 October 2019.

support considerations of legal justice over those of systemic patient safety and learning, not least as the ability of the High Court to consider disclosure as potentially deterring information provision is questionable given that the HSSIB has powers to compel interviews and information provisions. With multiple avenues of information and powers of investigation – as well as the HSSIB's final reports being available – other bodies do not need access to protected material simply because of the HSSIB's existence. We recommend that the Bill be amended to put beyond any possible doubt that the 'safe space' cannot be compromised save in the most exceptional circumstances, and therefore that the prohibition on disclosure applies equally to disclosure to coroners.

41. Further, there needs to be clarification as to how the government expects these provisions to work, for example where disclosure may take place and the level of where the bar is set in considering disclosure. We believe that there needs to be a tighter drawing of the boundaries of safe space to ensure its appropriate preservation and in turn support participants in playing their full role in an investigation. We think that the tests for an application to disclose protected materials must be sufficiently strong to ensure that disclosure is only sought in extremis, that there is a clear and overriding public interest in any disclosure, that the anonymity, safety and privacy of participants is respected without exception, and that current and future investigations are not jeopardised.

42. We are further concerned about the provision in the Bill (Clause 36 Power of direction: investigation functions) which would allow the secretary of state to direct HSSIB. It is critical to the effectiveness of HSSIB that it is independent and able to investigate the health system, and make recommendations in support of improving patient safety, without fear or favour. This is what makes HSSIB distinct from other national bodies, and it must be preserved for the sake of its credibility and integrity.

43. It would also be helpful to understand the intended approach to the maternity investigations currently undertaken by HSIB. HSIB has had a valuable role in identifying how NHS providers can sustainably and systematically improve the quality of their maternity investigations and then appropriately support those providers to make the required improvements. However, it remains important for these investigations return to the NHS at an appropriate point to ensure proper accountability, to support a trust's relationships with the affected families and staff, and to avoid the loss of skill within the NHS in carrying out such investigations.

Hospital food standards

44. We support the ambition to make food in hospitals safer, healthier and more sustainable, as it is an important factor in patient recovery and wellbeing. Trusts are already working hard to ensure they meet nutritional standards and provide good quality food. Arrangements for catering within trusts vary. Some do not have the kitchen facilities to be able cater on site for patients, and so they will have links with national wholesale suppliers. Elsewhere, some trusts have been able to develop close links with local suppliers, and others have been able to maintain their own

kitchens. These differences will have an impact on how quickly, and at what cost, individual trusts will be able to comply with any new nutritional requirements. Potential cost implications could include investment in additional workforce and facilities. There would also be costs associated with renegotiating and winding down contracts and arrangements with suppliers/outsourced caterers. There must therefore be a statutory period of consultation on any new nutritional requirements before they are made to avoid unintended consequences and unrealistic asks of trusts.

Conclusion

45. The Health and Care Bill is the most significant piece of health legislation in over a decade with far reaching implications for the health and care system. We welcome a number of measures set out in the Bill, but believe that further scrutiny on some key issues as outlined in this submission is vital. NHS Providers will continue to work constructively with the government and politicians to ensure this wide ranging piece of legislation delivers transformation and high quality care for patients.