Trusts IN SYSTEMS

NHS Providers

A GUIDE TO THE HEALTH AND CARE ACT 2022

for trusts and foundation trusts

JULY 2022

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CONTENTS

OVERVIEW

The Health and Care Act 2022 (the Act) contains the biggest reforms to the NHS in nearly a decade, laying the foundations to improve health outcomes by joining up NHS, social care and public health services at a local level and tackling growing health inequalities.

The majority of the Act is focused on developing system working with integrated care systems (ICSs) being put on a statutory footing through the creation of integrated care boards (ICBs). It also moves the NHS away from competitive retendering by default and towards collaborative delivery.

The Act formally merges NHS England and NHS Improvement and gives the secretary of state a range of powers of direction over the national NHS bodies and local systems and trusts. Other provisions include putting the Healthcare Safety Investigation Branch (HSIB) on a statutory footing; a new legal power to make payments directly to social care providers; the development of a new procurement regime for the NHS; and a new duty on the secretary of state to report on the system for assessing and meeting the workforce needs of the health service in England. The NHS will have to have regard to the wider effects of its decisions ('the triple aim duty'), and new duties will apply with regards to the environment. Regulations are planned to eradicate modern slavery and human trafficking from supply chains.

Provisions in the Act come into force at different times.

This guide provides a summary of the key parts of the Act for trusts and ICBs. It sets out:

- the main provisions relevant to providers and systems
- the secondary legislation that will flow from the Act
- what you can expect in terms of guidance on the Act
- the support NHS Providers will provide to you as the Act is implemented
- how NHS Providers worked to shape provisions in the interests of our members and service users.

This document is intended to be a guide to the Act to help make it more readily accessible to NHS trusts and foundation trusts. It focuses on those sections we expect to be of most relevance and interest to trust leaders. For the full detail of provisions, please see the full text of the Health and Care Act 2022.

National context

Within the guide, text that sets out the national policy context or highlights guidance or regulations related to the Act is highlighted in a light green box.

NHS Providers view and activity

NHS Providers' activity to influence the legislation, and our view on the final proposals, is highlighted in an dark green box.

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THE ACT ON A PAGE

- **The most significant changes brought about by the Act are:**
  - establishing ICBs and abolishing clinical commissioning groups (CCGs)
  - moving away from competitive retendering by default and towards collaborative delivery
  - formally merging NHS England and NHS Improvement.
- **ICBs:**
  - an ICB and its partner trusts and foundation trusts must prepare a five-year forward plan to meet the local population's health needs and aim to break even financially each year.
- **Social care:**
  - the Act establishes a cap on the amount that adults can be required to pay towards eligible care costs over their lifetime. This is expected to apply from October 2023.
- **The secretary of state's powers:**
  - the secretary of state no longer has to set the mandate to NHS England for each financial year, and instead it can be set at any time and remain in force until it is replaced by a new mandate
  - the secretary of state gains a range of powers of direction, including intervention powers in relation to significant reconfiguration proposals
  - minimum standards for food and drink provided in hospitals can be set.
- **Regulatory powers and statutory bodies:**
  - the national tariff is replaced with a new NHS payment scheme
  - NHS England has the power to apply a capital spending limit to a foundation trust for a single financial year
  - the Care Quality Commission (CQC) will oversee and assess ICSs, and local authority adult social care duties
  - the Health Services Safety Investigations Body (HSSIB) is put on a statutory footing.
- **Statutory duties:**
  - the 'triple aim' duty requires the NHS to have regard to the wider effect of decisions on health and wellbeing, the quality of services, and efficiency and sustainability
  - trusts and foundation trusts have duties regarding climate change and the environment, and regulations are planned to eradicate slavery and human trafficking from supply chains.

2 OVERVIEW OF INTEGRATED CARE BOARDS

Since 2016, health and care organisations have increasingly been working together in England to coordinate services and to improve population health and reduce inequalities between different groups. The formation of non-statutory ICSs accelerated this change.

ICSs were voluntary coalitions bringing together NHS providers, local authorities, and voluntary sector partners to collaboratively plan and organise how health and care services were delivered in their area. CCGs were the statutory bodies responsible for commissioning and planning of health care services in a local area. There were 42 ICSs across England, and each covered a population size of 1 to 3 million. The goal was to remove barriers between organisations to deliver better, more joined up care for local communities.

This Act moves these voluntary coalitions onto a statutory footing by establishing statutory ICBs. The ICBs will take on the commissioning functions of CCGs as well as some of NHS England's commissioning functions. However, an ICB is not simply a larger CCG. The ICB governance model reflects the need for integration and collaboration across the system. An ICB will have the ability to exercise its functions through place-based committees (while remaining accountable for them) and it will also be directly accountable for NHS spend and performance within the system.

The ICB will, as a minimum, include a chair, chief executive officer, and representatives from NHS trusts and NHS foundation trusts, general practice and local authorities. The chair must ensure that at least one ordinary member has knowledge and experience of mental health services. Beyond that, local areas will have the flexibility to determine any further representation in their area. ICBs will also need to ensure they have appropriate clinical advice when making decisions.

Each ICB and its partner local authorities will be required to establish an integrated care partnership (ICP), bringing together health, social care, public health and representatives from the wider public space where appropriate, such as social care providers or housing providers. The ICP will be tasked with developing a strategy to address the health, social care and public health needs of its system. The ICB and local authority (or authorities) will have to have regard to that plan when making decisions.

The Act introduces a new duty on the CQC to conduct reviews of ICBs, local authorities and their system partners working collectively. These reviews will assess the provision of NHS care, public health and adult social care within the ICB area. They will consider how well the ICBs, local authorities, and CQC registered providers discharge their functions in relation to the provision of care as well as the functioning of the system as a whole, which will include the role of the ICP.

3 THE HEALTH AND CARE ACT 2022

Part 1: Health service in England: integration, collaboration and other changes

NHS England (sections 1-17; Schedule1)

Summary

These sections make a number of provisions related to NHS England and its ways of working. This includes:

- renaming the NHS Commissioning Board as NHS England
- giving the secretary of state the power to veto any proposal from NHS England on the commissioning of specialised services
- changes to how and when the mandate to NHS England is set
- requiring greater transparency on mental health spending
- applying the triple aim duty to NHS England, requiring it to have regard to the likely wider effects of making any decision to exercise its functions.

Further provisions include:

- broadening the powers of NHS England to give assistance and support to any provider of NHS services or any body carrying out the functions of the NHS (this includes ICBs and non-NHS bodies providing NHS services)
- enabling NHS England to give directions to one or more ICBs in respect of any of the ICB's functions (including delegation arrangements) and payments. Regulations may be made limiting this power. The rights and liabilities incurred by an ICB as a result lie with the ICB alone
- extending the right to be included in public involvement and consultation to carers and representatives
- requiring the objectives specified in the mandate to include outcomes for cancer patients, with those objectives to be treated by NHS England as having priority over any other objectives relating to cancer performance (such as process measures).

In addition:

- NHS England is required to prepare consolidated accounts for NHS trusts and foundation trusts and submit them to the secretary of state and the comptroller and auditor general, and then to parliament along with any related report of the comptroller and auditor general
- NHS England has a duty to reduce inequalities and to set out the powers of NHS bodies to assess inequalities, as well as to report on the extent to which these powers have been exercised each year
- the secretary of state has the power to direct NHS England in the use of payments made to it for the purpose of integration. NHS England can make payments to ICBs in respect of integration

- payments for quality can be designated by direction, with the previous power of the secretary of state to make regulations in respect of these payments removed
- the right of NHS England to accept secondments from designated bodies is extended.

Key sections

Section 3: Mental health spending

The secretary of state will publish each financial year the government's expectations as to increases in the amount in, and in the proportion of, mental health spending by NHS England and ICBs and explain why. ICBs will also be required to report on mental health spending.

NHS Providers view and activity

We encouraged parliamentarians to support amendments which introduced transparency on mental health spending into the Act and widened the definition of 'health' to include mental health in the NHS Act 2006.

Section 4: NHS England mandate: general

This section removes the 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 it is replaced by a new mandate.

These changes remove the statutory link between the mandate and the annual financial cycle, and in future NHS England's annual limits on capital and revenue resource are given statutory force through financial directions.

Section 8: NHS England: wider effect of decisions

This section places a duty on NHS England to have regard to the likely effects of making any decision to exercise its functions on:

- the health and wellbeing of the people of England
- the quality of health services provided
- efficiency and sustainability across the NHS.

NHS England must produce guidance as to how it will exercise this duty. References to health and wellbeing and the quality of services provided must include a reference to its effects in relation to inequalities.

National context

NHS England is developing guidance setting out expectations for how NHS bodies should work in partnership with people and communities. They are also developing guidance on the 'triple aim' duty.

This section applies the triple aim duty to NHS England, with later sections applying it to ICBs, trusts and foundation trusts, as well as in the context of the licensing of healthcare providers (see sections 25, 52, 67 and 76).

NHS Providers view and activity

This legislates for decision-making which balances health and wellbeing, the quality of services, and efficiency and sustainability within a constrained resource envelope. While in many ways this reflects the status quo, this section does offer a new legal basis for decisions. Our expectation is that such decisions would always be clinically led and evidence-based, but this may nevertheless be concerning for services which have been subject to local variation in the past.

Section 15: Funding for service integration

This makes provision for a fund for the integration of care and support with health services, known as the Better Care Fund (BCF), and allows for the secretary of state to provide directions requiring NHS England to use a specified amount of this annual payment for purposes relating to service integration. This provision has to come into force before April 2023.

Where the secretary of state has given a direction about the use by NHS England of the annual amount, NHS England may direct ICBs that a designated amount of the annual payment is to be used for purposes of service integration.

National context

The intention is to decouple the BCF from the process of producing the NHS England mandate, rather than to fundamentally change the focus of the BCF.

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Integrated care boards and Integrated care boards: functions (sections 18-25; Schedules 2 and 3)

Summary

This chapter of sections and its schedules amend the National Health Service Act 2006 (the 2006 Act) to describe the composition, constitution, and functions of ICBs.

NHS Providers view and activity

NHS Providers worked extensively with the Department of Health and Social Care (DHSC) and NHS England to maintain sufficient flexibility for ICBs and their constituent organisations to design what works locally. This included securing drafting changes before the Bill was published which means an ICB will be required to work with its partner trusts and foundation trusts in preparing its five-year forward plan.

We also successfully secured ministerial assurances that the provision to prevent private providers from sitting on the ICB or its committees would not inadvertently prevent social enterprises or NHS providers from participating.

Key sections

Section 19: Establishment of integrated boards; and Schedule 2

National context

NHS England will be publishing guidance on the process for amending ICB constitutions. Subsequent guidance will address the duty of ICBs to review the skills and experience of their board.

ICBs will take on the commissioning functions and duties of CCGs, which will be abolished on the same day (1 July 2022) that ICBs are established as corporate bodies. The CCGs within the system footprint must consult with relevant parties and propose the first ICB constitution, taking into account any guidance published by NHS England (such as the guidance to CCGs on preparing ICB constitutions).

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The composition of an ICB will, at a minimum, consist of a chair, chief executive and at least three other members. One of those members is jointly nominated by NHS trusts and foundation trusts, one by primary care services and one by local authorities providing services within the ICB footprint. Beyond that, local systems will have the flexibility to determine any further membership. NHS England will appoint the ICB chair and have the power to remove them, with secretary of state approval in either instance. The ICB chief executive will be appointed by the chair, with NHS England approval. The chair will approve the appointment of ordinary members (that is, member other than the chair or chief executive).

National context

Who can nominate an ICB member? The secretary of state laid draft regulations in May 2022 setting out which trusts, foundation trusts and primary care providers may participate in the process for nominating partner members to the ICB board. NHS England also set out the criteria in Guidance to CCGs on the preparation of ICB constitutions (13 May 2022).

Trusts will be eligible if they are essential to the development and delivery of the ICB's five-year forward plan, including those that work across several systems (such as ambulance trusts). Where a trust or foundation trust does not meet this condition, they will be eligible in the ICS where they receive the largest proportion of ICB income.

Each ICB must publish its constitution, which should set out how members are to be appointed and by whom, and the process for nominating ordinary members (Schedule 2). The constitution must also provide for committees or sub-committees of the ICB to be formed. NHS England will publish guidance in relation to the selection of candidates. The Act gives significant flexibility on the membership of ICB committees, allowing individuals to be appointed who are neither ICB board members nor employees.

National context

NHS England stated in guidance on ICB constitutions (May 2022) that it is likely that ICBs will need to establish committees to support the board and exercise any delegated functions.

A number of requirements for ICBs have been set. This includes an ICB board being required to keep under review the skills, knowledge, and experience that it is necessary to have on the board and take steps to address or mitigate shortcomings. The chair must ensure that at least one ordinary member has knowledge and experience of mental health services. In addition, the constitution must prohibit the appointment of someone if the board considers that the appointment could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise (Schedule 2).

National context

During the passage of the legislation, parliamentarians made clear that they wanted to see clearer executive leadership on certain issues. The guidance on the preparation of ICB constitutions (May 2022) confirms how an ICB is required to identify named executive board member leads for safeguarding and special educational needs and disabilities (SEND), and for children and young people's services. The guidance states that these are not new statutory duties or additional board posts, but rather intended to secure visible board-level leadership of these issues.

Section 21: Commissioning hospital and other health services

This amends section 3 of the NHS Act to require ICBs to commission hospital and other health services for those persons for whom the ICB is responsible.

Section 22: Commissioning primary care services etc; and Schedule 3

This inserts Schedule 3 which amends the NHS Act 2006 to give integrated care boards responsibility for medical, dental and ophthalmic primary care functions. It contains other amendments relating to primary care services.

Section 25: General Functions

An ICB has several duties, including but not limited to:

- improving the quality of services, reducing inequalities in access and outcomes
- promoting integration between health, social care and wider services
- having regard to the 'triple aim'.

Further, an ICB must:

- ensure patients and communities are involved in the planning and commissioning of services
- have regard to NHS England's guidance for ICBs on the discharge of their functions
- manage conflicts of interest.

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Section 25 (along with Schedule 2) sets out that the ICB and its partner trusts and foundation trusts must prepare a five-year forward plan setting out how they propose to exercise their functions. In doing so, they need to have regard to and consult with relevant health and wellbeing boards (HWBs) and their strategies. The plan must set out any steps that the ICB proposes to take to address the particular needs of children and young people, and any steps the ICB proposes to take to address the particular needs of victims of abuse (including domestic abuse and sexual abuse, whether of children or adults). An HWB may give NHS England its views on whether an ICB's plan takes into account local health and wellbeing strategies sufficiently.

National context

We expect DHSC guidance on the areas it thinks the integrated care strategy is well placed to address, and that this will inform the creation of integrated care strategies by December 2022 (ahead of the ICB's five-year forward plan due in April 2023).

NHS England will publish guidance in autumn 2022 setting out further expectations on the ICB's five-year forward plan.

An ICB and its partner NHS trusts and NHS foundation trusts must also create a joint capital resource plan for a period specified by the secretary of state. The ICB must prepare accounts and create an annual report. Each ICB must produce and publish an annual report on how it has discharged its functions, as well as its performance on the forward plan and capital resource plan. The annual report must also cover information relating to inequalities and mental health expenditure. NHS England will also have the power to obtain information from ICBs.

NHS England will conduct a performance assessment of each ICB each financial year. If NHS England deems an ICB to be failing or at risk of failure, NHS England will have powers of direction over the ICB (including prohibiting or restricting the ICB from delegating functions) and may terminate the appointment of the chief executive and direct others to exercise the ICB's functions.

The Act confers a duty on ICBs to commission primary care, and NHS England may direct an ICB to exercise any of NHS England's primary care functions (Schedule 3).

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NHS Providers view and activity

NHS England published its Roadmap for integrating specialised services within Integrated Care Systems on 31 May 2022 outlining how it envisages commissioning arrangements for specialised services developing over the next few years, following ICSs taking statutory form in July. Our preliminary analysis can be found here.

Integrated care partnerships (section 26)

Summary

The Act states that an ICB and relevant local authorities must establish a statutory joint committee for the system – an ICP – which will bring together partners from across the system to address the health, social care and public health needs of the population. The ICP membership includes one member appointed by the ICB, one member appointed by each of the relevant local authorities, and any other members appointed by the ICP. The ICP will be able to determine its own procedures locally.

Each ICP must prepare an 'integrated care strategy', building on the relevant joint strategic needs assessments to meet the assessed needs of the local population. This strategy must consider the effectiveness of establishing section 75 arrangements[1] , the NHS mandate and guidance issued by the secretary of state. Healthwatch and local communities must be involved in its creation. An ICP may include in this strategy a statement of its views on how the provision of health-related services could be more closely integrated with health and social care services. The strategy must detail how it will be delivered by the ICB, NHS England or the responsible local authority. If the ICB and local authority decide that joint local health and wellbeing strategies do not sufficiently address how the population's needs will be met, a new strategy will need to be prepared.

[1] Section 75 of the National Health Service Act 2006 allows NHS bodies and local authorities to contribute to a common fund which can be used to commission health or social care related services.

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National context

We expect DHSC statutory guidance in July 2022 on the integrated care strategy. We expect this guidance to set out that the strategy should consider child health and wellbeing outcomes and the integration of children's services. We understand ICPs will be required to consult children's system leaders, and children and families themselves, on the strategy. ICPs, where appropriate, will be expected to consider in the integrated care strategy where there are opportunities to further integrate family hub arrangements with health and social care services.

Integrated care system: financial controls (section 27-30)

Summary

These sections set out the financial responsibilities of NHS England and ICBs. Each ICB must exercise its functions with a view to breaking even. Furthermore, each ICB and its partner trusts and foundation trusts must seek to achieve financial objectives set by NHS England and operate with a view to ensuring that local capital and revenue resource use does not exceed the limits specified in directions by NHS England in that financial year. NHS England may give directions to an ICB and its partner trusts and foundation trusts to ensure that they do not exceed these limits.

Section 29: Financial responsibilities of integrated care boards and their partners

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 CCGs and trusts under the Health and Social Care Act 2012 and NHS Act 2006 respectively.

NHS Providers view and activity

The intention behind these provisions 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.

There is no objection mechanism in this provision despite there being a clear link between the funding available to a provider and its ability to deliver safe care. However, during proceedings in the House of Commons, 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. In line with the reforms to the NHS cash regime in 2020, trusts can access short-term revenue support in the form of public dividend capital. There may be circumstances where an ICB holds a deficit but the overall system delivers financial balance – in this case NHS England must be informed at the earliest opportunity. NHS England's 2022/23 revenue and contracting guidance also makes clear that if ICBs overspend in a given year, an additional interim efficiency requirement must be met by the ICB the following year.

Integrated care system: reviews and further amendments (sections 31-32; Schedule 4)

Summary

The Act introduces new duties on the CQC to review ICS service provision and local authority adult social care responsibilities.

Key sections

Section 31: Care Quality Commission reviews etc of integrated care system

The CQC must conduct and publish reviews of the provision of relevant health care, and adult social care, within the area of each ICB. Its assessment will take into account how the board, its partner local authorities and registered service providers work together, as well as how the system functions as a whole.

The secretary of state will set the priorities and objectives of ICS reviews. The Act specifies a focus on leadership, integration, quality and safety. The CQC will determine the indicators of quality, methods, period, and frequency of these reviews with secretary of state approval.

NHS Providers view and activity

We sought and received assurances on the floor of the House that these powers will be used infrequently by the government so as not to disrupt CQC reviews. The government also affirmed that the government will fully respect the independence of the CQC.

Section 32: Integrated care system: further amendments; and Schedule 4

Schedule 4 contains minor and consequential amendments.

Merger of NHS bodies (sections 33- 39; Schedule 5)

Summary

These sections provide for the abolition of Monitor and the Trust Development Authority (TDA) and place a duty on NHS England to minimise and manage the risk of conflict between its regulatory and other functions.

Key sections

Section 33: Abolition of Monitor and transfer of functions to NHS England; and Schedule 5

This provides for the abolition of Monitor, with Schedule 5 making consequential amendments relating to the transfer of Monitor's functions to NHS England.

Section 34: Exercise by NHS England of new regulatory functions

This provision places a duty on NHS England to minimise the risk of conflict between its regulatory and other functions, and to manage any conflicts that arise.

Section 35: Modification of standard licence conditions

This section adds to current provisions to require an impact assessment before modification of standard licence conditions in all providers' licences or in licences of a particular description is allowed.

Section 36: Abolition of NHS Trust Development Authority

This provides for the transfer of powers from the TDA to NHS England and abolishes the TDA.

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Secretary of state's functions (sections 40-47; Schedule 6)

Summary

These sections set out a number of powers of direction for the secretary of state, including in relation to public health, NHS England, safety investigations and reconfiguration. There is also a duty on the secretary of state regarding publication of an assessment of the workforce needs of the health service in England.

Key sections

Section 41: Report on assessing and meeting workforce needs

Section 41 sets out a duty on the secretary of state to publish, at least once every five years, a report describing the system for assessing and meeting the workforce needs of the health service in England. It also places a duty on Health Education England (HEE) and NHS England to assist the secretary of state in preparing the report, if asked by the secretary of state to do so.

NHS Providers view and activity

NHS Providers, along with a coalition of more than 100 health and care organisations, sought to persuade government and parliament of the need for greater robustness and transparency in support of long-term workforce planning. The coalition amendment was successful in the House of Lords but ultimately the government did not accept our proposals. We are disappointed that the provisions in the Act remain limited to publication of a description of the system and will continue to argue for a fully costed and funded workforce plan.

Section 42: Arrangements for exercise of public health functions

Section 42 allows for any of the secretary of state's public health functions to be exercised by NHS England, an ICB, a local authority that has duties to improve public health, a combined authority, or any other body that is specified in regulations.

Section 43: Power of direction: public health functions

This allows the secretary of state to direct NHS England or an ICB to exercise any of the public health functions of the secretary of state and provides for funding in relation to the functions to be exercised.

Section 44: Power of direction: investigation functions

This enables the secretary of state to direct NHS England (if considered to be in the public interest) or any other public body to exercise any of the investigation functions which are specified in the direction. The investigation functions here are those carried out, prior to this Act, by the HSIB under ministerial directions.

National context

Further to this section, we understand that the HSSIB will not have responsibility for HSIB's maternity investigation programme. This will instead be transferred for five years to a new special health authority (SHA) which will be operational from April 2023 after secondary legislation is passed.

Section 45: General power to direct NHS

Section 45 gives the secretary of state the power to direct NHS England in relation to its functions. There are exceptions to this power – the secretary of state cannot use the power in relation to the appointment of individuals by NHS England (including trusts and foundation trusts), individual clinical decisions, or in relation to drugs or treatments that the National Institute for Health and Care Excellence (NICE) have not recommended or issued guidance on as to clinical and cost effectiveness.

If NHS England fails to comply with a direction, the secretary of state may discharge the functions to which the direction relates or make arrangements for someone else to discharge them. When the secretary of state exercises this power, the reasons for doing so must be published.

Section 46: Reconfiguration of services: intervention powers; and Schedule 6

Section 46 gives the secretary of state intervention powers in relation to the reconfiguration of NHS services. Arrangements are detailed in Schedule 6, which places a duty on an NHS commissioning body (that is, NHS England or an ICB) to notify the secretary of state when there is a proposal to reconfigure services.

The secretary of state must be notified about significant reconfiguration proposals.

The secretary of state may also call in any reconfiguration proposal, and may require consideration at any stage of the reconfiguration process.

The secretary of state has the power to take any decision which could have been taken by the NHS commissioning body. This includes:

- whether the proposal should or should not proceed, or whether it should proceed in a modified form
- the particular results that should be achieved by the NHS commissioning body in relation to its decision on the proposal
- any procedural steps that should be taken
- retaking any decision previously taken by the NHS commissioning body.

The secretary of state is required to give relevant bodies an opportunity to make representations, and there is a six-month limit for the secretary of state to make a decision.

NHS Providers view and activity

NHS Providers, working with the King's Fund and NHS Confederation, persuaded the government to add important safeguards that greatly reduce the risk of political interference in the exercise of these powers. These changes mean the secretary of state will only need to be notified about significant reconfiguration proposals – initially, any and all potential reconfigurations were required to be notified. The secretary of state will also have to make a decision within six months.

Health minister Edward Argar MP confirmed in the House of Commons that the secretary of state would consult any relevant providers who are responsible for delivering services, and that this will be reflected in forthcoming guidance and regulations.

Section 47: Review into NHS supply chains

This introduces a duty on the secretary of state to undertake a review of NHS supply chains and to make regulations with a view to assessing and mitigating the risk of the use by the NHS in England of goods or services involving slavery or human trafficking. The regulations can set out steps the NHS should be taking to assess the level of risk associated with individual suppliers, and the basis on which the NHS should exclude them from a tendering process.

NHS trusts (sections 48-60; Schedule 7)

Summary

A number of sections in this chapter repeal redundant legislative sections, including some legislation which was never commenced (for example, provision in the Health and Social Act 2012 for the formal abolition of NHS trusts was never commenced because the foundation trust pipeline was not completed as initially envisaged).

Key sections

Section 48: NHS trusts in England

This section repeals section 179 of the 2012 Act. Section 179 of the 2012 Act abolishes NHS trusts in England. As not all NHS trusts converted to NHS foundation trusts, NHS trusts still exist, and this section has never been commenced.

Section 49: Removal of power to appoint trust funds and trustees

This clause repeals paragraph 10 of Schedule 4 of the NHS Act 2006 which allows the

secretary of state to appoint trustees for an NHS trust to hold property on trust. This section removes the secretary of state's powers to appoint such trustees.

Section 50: Sections 48 and 49: consequential amendments; and Schedule 7
Schedule 7 contains amendments that are consequential on sections 48 and 49.

Section 51: Licensing of NHS trusts
Section 51 removes the exemption on NHS trusts to hold a licence from NHS England and requires NHS England to treat any new NHS trusts as if they had applied for a licence – effectively bringing the provider licence in line with the approach for foundation trusts.

Section 52: NHS trusts: wider effect of decisions
This creates a duty to have regard to the 'triple aim' of better health for everyone, better care for all, and efficient use of NHS resources. In addition, consideration will also need to be given to its effects in relation to health inequalities. This applies to ICBs, NHS England and foundation trusts and trusts in England (the 'relevant bodies').

Decisions relating to services provided to a particular individual (for example individual clinical decisions or highly specialist commissioning decisions concerning an individual patient) are exempt from this duty.

Section 53: NHS trusts: duties in relations to climate change
NHS trusts, in the exercise of their functions, must have regard to and contribute towards compliance with section 1 of the Climate Change Act 2008 (UK net zero emissions target), and with section 5 of the Environment Act 2021 (environmental targets), and adapt to any current or predicted impacts of climate change identified in the most recent report under section 56 of the Climate Change Act 2008.

Section 54: Oversight and support of NHS trusts
Section 55: Directions to NHS trusts
Section 56: Recommendations about restructuring of NHS trusts
Section 57: Intervention in NHS trusts
Section 59: Appointment of chair of NHS trusts
Sections 54-57 and 59 effectively give NHS England existing powers previously held by the TDA and/or the secretary of state in relation to NHS trusts.

Section 58: NHS trusts: conversion to NHS foundation trusts and dissolution
Section 58 means that an application by an NHS trust to become a foundation trust no longer requires the support of the secretary of state. However, authorisation may only be given for foundation trust status if the secretary of state approves the authorisation and NHS England is satisfied.

This section also gives NHS England the power to dissolve a trust on the approval of the secretary of state and allows NHS England or the secretary of state to make the order for dissolution, if either consider it appropriate to do so. Neither the secretary of state nor NHS England may make a dissolution order until after the completion of a consultation unless as a matter of urgency or following the publication of a final report from a trust special administrator.

Section 60: Financial objectives for NHS trusts

This section amends existing legislation such that NHS England, rather than the secretary of state with the consent of HM Treasury, may set financial objectives for trusts. As is the case now, trusts must achieve these objectives. Furthermore, objectives may apply to trusts generally, or to a particular trust or trusts of a particular description.

NHS foundation trusts (sections 61-68)

Summary

These sections cover the licensing of foundation trusts and the application of capital spending limits, as well as requirements with regards to producing accounts, reports and forward plans. Mergers, acquisition, separations and dissolution procedures are also included, as well as new duties on tackling climate change and inequalities.

Key sections

Section 61: Licensing of NHS foundation trusts

NHS England can treat existing foundation trusts and new foundation trusts created via merger as having applied and been granted a licence.

Section 62: Capital spending limits for NHS foundation trusts

This gives NHS England the power to set a capital expenditure limit for a foundation trust. Therein:

- NHS England has the power to establish an order to set a capital expenditure limit on a foundation trust in respect of a single financial year
- the order must specify the financial year to which the limit relates (and may be made at any time during or before that financial year)
- NHS England must consult with the foundation trust before the order is made and must publish the order
- the foundation trust has a duty not to exceed the capital expenditure limit set for the relevant financial year.

NHS England must produce guidance on the use of its power to make orders, and NHS England is required to consult with the secretary of state before publication of such guidance. The guidance (now published) sets out information about the circumstances in which NHS England is likely to make an order to set a capital expenditure limit for a foundation trust and how it will establish the limit. NHS England must have regard to the guidance when deciding whether to issue any orders to limit capital expenditure by foundation trusts, and to keep the guidance under review.

NHS Providers view and activity

Foundation trust boards need to have appropriate power to spend sufficient capital to deliver the right quality of care. As the proposals for this legislation were developed, we negotiated a set of safeguards with the government and NHS England around the use of powers to set foundation trust capital limits. That agreement was for a reserve power, to be used only as a last resort, applying to a single named foundation trust and automatically ceasing at the end of the current financial year. We were also concerned to ensure a transparent process with any order published. We ensured that these were appropriately carried through, and the Act and associated guidance reflect these commitments.

Section 64: NHS foundation trusts: joint exercise of functions

This section makes it possible for an NHS foundation trust to carry out its functions jointly with another organisation. The Act creates a legal mechanism to allow ICBs and NHS providers to form joint committees, of two or more providers, to make joint arrangements and pool funds.

Parallel measures in the Act make it easier for an ICB to commission services collaboratively with other ICBs and other system partners by permitting a wider set of arrangements for joint commissioning, pooling of budgets and delegation of functions.

National context

NHS England will publish in summer 2022 guidance for ICBs, trusts and foundations on the new flexibilities in the Act on delegation, joint working and pooled funds. We have engaged extensively with NHS England on the draft guidance, including holding engagement sessions with trust leaders at different stages of its development (January and May).

Section 65: NHS foundation trusts: mergers, acquisitions and separations

This section removes the requirement that an application to merge a foundation trust with an NHS trust must be supported by the secretary of state. An application to acquire a foundation trust or a trust similarly no longer requires the support of the secretary of state. This section places a duty on NHS England to grant the application if it was satisfied that necessary steps have been taken to prepare for the dissolution and the establishment of the new trust or acquisition and the secretary of state approves the grant of the application.

Section 66: Transfers on dissolution of NHS foundation trusts
The section removes the requirement for the grant of an application made by a foundation trust for dissolution to be based on having no liabilities, as was previously set out in the 2006 Act.

NHS England will also be required once the application for dissolution has been granted, to transfer, or provide for the transfer of, the property and liabilities (including criminal liabilities) to another foundation trust, trust, or the secretary of state. It also imposes a duty on NHS England to include in the order a provision for the transfer of any employees of the dissolved foundation trust.

Section 67: NHS foundation trusts: wider effect of decisions
This reflects and reiterates the statutory triple aim duty.

Section 68: NHS foundation trusts: duties in relation to climate change
This reflects and reiterates the duties pertaining to climate change.

NHS foundation trusts (sections 69-70; Schedule 8)

Key sections

Section 69: transfer schemes between trusts
This section allows NHS England to make one or more schemes to transfer property rights, and liabilities from a relevant NHS body to another relevant NHS body, such as an NHS trust or foundation trust. The section also allows NHS England to set out what steps need to be taken before an application can be granted and what should be included in the scheme.

Section 70: Trust special administrators; and Schedule 8
This outlines the changes to the process and authorisation for the appointment of trust special administrators, including reporting mechanisms.

Joint working and delegation of functions (sections 71-72; Schedule 9)

Summary
These provisions enable NHS England, ICBs, trusts and foundation trusts to exercise their functions jointly with each other and/or with local authorities. It also enables trusts and foundation trusts to establish joint committees and pooled funds with other trusts, foundation trusts, NHS England and ICBs and/or local authorities. NHS England may publish guidance for NHS bodies in relation to joint working and delegation arrangements.

Key sections

Section 71: Joint working and delegation arrangements
This enables trusts and foundation trusts to establish joint working and delegation arrangements, as well as joint committees and pooled funds with other trusts, foundation trusts, NHS England and ICBs, and/or local authorities. In relation to joint working and delegation arrangements, 'any rights acquired, or liabilities (including liabilities in tort)

incurred, in respect of the exercise by a body of any function by virtue of this section are enforceable by or against that body (and no other person)'. Terms can be agreed regarding payments, and regarding prohibiting or restricting a body from making delegation arrangements in relation to relevant functions. Where a delegated function is jointly exercised, a joint committee may be established, and a pooled fund created.

Section 72: References to functions: treatment of delegation arrangements etc; and Schedule 9

This inserts a new section 275A into the NHS Act 2006. It is intended to produce a more consistent approach to the way in which functions are referred to in the Act.

National context

NHS England will publish guidance for ICBs, trusts and foundation trusts on the new flexibilities in the Act on delegation, joint working and pooled funds; and on joint appointments in summer 2022.

NHS Providers view and activity

The nature of and arrangements for joint committees have important implications for trust boards. Any joint committee would not be a body corporate, and its members would not be protected in the same way as board members are protected. As decisions would be made under delegation, there would be an absence of non-executive director (NED) challenge because foundation trusts cannot delegate to NEDs. Should anything go wrong liability would lie with the foundation trust that made the delegation.

When joint committees make decisions by a majority it presents risks for foundation trusts that will need to be managed. Joint committees are likely to lack the necessary provisions for challenge and obtaining assurance, so boards will need to keep a close eye on them and monitor whether the joint committee process works for them. It is worth noting that if decisions by a joint committee lead to a service failure, it will be the trust board(s) that provide the service who will be taken to task.

We also note the ambiguous wording within this section relating to rights acquired and liabilities incurred. It seems that this provision relates to the delegating body, but as that body may be working with others to delegate and in doing so, take on functions, we await further clarity. Consideration might also be given as to whether a delegation or a contractual arrangement would be preferable, bearing in mind that rights and liabilities are not shared among the parties to these arrangements.

Collaborative working (sections 73-76)

Summary

These provisions remove the secretary of state's and NHS England's duty to promote autonomy and establishes what guidance NHS England can issue concerning joint appointments. The secretary of state can also issue guidance on the duty imposed on NHS bodies to co-operate. Provision is also made to include the new triple aim duty within licence conditions.

Key sections

Section 73: Repeal of duties to promote autonomy

This removes the secretary of state's and NHS England's duties to promote autonomy. NHS England will continue to function as an arm's length body. The removal of this duty is to allow for the introduction of section 45 (general power to direct NHS England) which gives the secretary of state the ability to direct NHS England in regard to the exercise of its functions.

Section 74: Guidance about joint appointments

This section gives NHS England the ability to issue guidance concerning joint appointments between:

- one or more relevant NHS commissioner and one or more relevant NHS provider
- one or more relevant NHS body and one or more local authority
- one or more relevant NHS body and one or more combined authority.

References here to NHS bodies mean NHS England, ICBs, trusts and foundation trusts. Ahead of publishing or revising any guidance, NHS England will be required to consult with appropriate organisations.

Section 75: Co-operation by NHS bodies etc

This introduces a new power for the secretary of state to make guidance on how the duty imposed on NHS bodies to co-operate with each other is discharged. It imposes a duty on NHS bodies, except for Welsh NHS bodies, to have regard to this guidance.

This section also sets out a duty on NHS bodies and local authorities (including Welsh NHS bodies and Welsh local authorities) to co-operate with one another in order to advance the health and welfare of the people of England and Wales. The secretary of state can publish guidance related to England and imposes a duty on NHS bodies and local authorities in England to have regard to this guidance.

Section 76: Wider effect of decisions: licensing of health care providers

This amends the 2012 Act to specify the purposes for which Monitor (whose functions will be transferred to NHS England) may set or modify the conditions contained in the licence which any provider of health care services for the purposes of the NHS must hold.

Further to the creation of the 'triple aim' duty, licence conditions may be set or modified to ensure that decisions are made with regard to all likely wider effects on the three factors which are included in the new 'duty to have regard to the effect of decisions'.

NHS payment scheme (section 77; Schedule 10)

Summary

Section 77 and Schedule 10 replace the national tariff with the NHS payment scheme and make provisions relating to the new scheme. The scheme will be published by NHS England, which will consult with ICBs and relevant providers across the NHS and independent sector. The scheme will set rules around how commissioners establish prices to pay providers for healthcare services for the purposes of the NHS, or public health services commissioned by an ICB or NHS England, on behalf of the secretary of state. The intention is to give the NHS more flexibility in how prices and rules are set, in order to help support more integrated care at local levels.

Key section

Section 77 and Schedule 10 (paragraph 114D): The NHS payment scheme
Paragraph 114D deals with objections to the NHS payment scheme. The Competition and Markets Authority (CMA) will no longer have a role in reviewing objections. Instead, NHS England will make its own decisions about how to proceed. If it decides to make amendments that are, in its opinion, significant and unfair to make without further consultation, it must consult ICBs and relevant providers again. If it decides not to make amendments, it may publish the NHS payment scheme alongside a notice stating that decision and setting out the reasons for it.

Patient choice and provider selection (sections 78-81; Schedule 11)

Summary

These sections and Schedule 11 revoke existing procurement and competition requirements. They also strengthen the current rules around patient choice by making it mandatory for regulations to contain provisions about how NHS England and ICBs will allow patients to make choices about their care and provide NHS England with new powers to enforce patient choice requirements. NHS England must publish guidance about how it intends to exercise its powers here. The intention is to pave the way for a new NHS provider selection regime that moves away from competitive retendering by default in favour of a more collaborative approach to planning and delivering services. Section 81 requires the secretary of state to make regulations with a view to eradicating the use in the health service that are tainted by slavery and human trafficking.

National context

The provider selection regime is due to be implemented by 1 December 2022. This new regime for arranging clinical health care services in England seeks to promote the best interests of patients, taxpayers and local communities. Under the provider selection regime, NHS England says, 'The regime is intended to make it straightforward for systems to continue with existing service provision where the arrangements are working well and there is no value for the patients, taxpayers, and population in seeking an alternative provider. And, where there is a need to consider making changes to service provision, it will provide a sensible, transparent, and proportionate process for decision-making that includes the option of competitive tendering as a tool decision-makers can use'. A government explainer can be found here.

NHS Providers view and activity

It will be important to ensure the provider selection regime operates transparently and robustly, and benefits all trust types, including mental health and community services, which have historically been subject to repeated retendering. Providers have also flagged the need for a proportionate challenge function to be built into the regime (below the high bar of a judicial review). We are continuing to work with NHS England, DHSC and other provider representative groups to explore how a peer review process might be built into the process to support local resolution if local stakeholders have cause to challenge a decision-making body's decision. You can see NHS Providers' response to the consultation on the regime and the Community Network's response.

Competition (sections 82-85; Schedule 12)

Summary

These sections and Schedule 12 introduce a duty on NHS England to provide assistance to the CMA, as well as removing the CMA's involvement in licensing and powers over trust mergers and removing Monitor's competition functions.

Key sections

Section 82: Duty to provide assistance to the CMA

NHS England will be required to give the CMA regulatory information that the CMA may need to exercise its functions, or which would assist it in carrying out its functions. This includes information held by NHS England relating to patient choice, oversight and support, and recommendations about restructuring.

Section 83: Mergers of providers: removal of CMA powers

This adds an exemption from Part 3 of the Enterprise Act 2002, removing CMA powers over trust mergers. Instead, NHS England will review mergers of NHS providers to ensure they are in the best interests of patients and the taxpayer.

Section 84: Removal of functions relating to competition etc; and Schedule 12

This removes Monitor's competition duties as set out in the 2012 Act.

Section 85: Removal of CMA's involvement in licensing etc

This removes Monitor's ability to refer contested licence conditions and tariff prices to the CMA. Instead, NHS England will make its own decisions on how to operate the licensing regime and the NHS payment scheme.

Miscellaneous (sections 86-91)

Summary

These provisions remove the three-year limit for Special Health Authorities (SpHAs) and includes a number of tidying up provisions related to their accounts and reports. In addition, the definition of 'health' as set out in the NHS Act 2006 is expanded to include mental health, and Local Education and Training Boards (LETBs) are abolished. There is also a new requirement on trusts to involve a patient and their carer when planning to discharge a patient.

Key sections

Section 87: Tidying up etc provisions about accounts of certain NHS bodies

This sets out requirements for SpHAs in relation to their accounts and auditing.

Section 88: Meaning of 'health' in the NHS Act 2006

This section amends the NHS Act 2006 so that 'health' will now include 'mental health'.

Section 89: Repeal of spent powers to make transfer schemes etc

This repeals the powers of the secretary of state in the 2012 Act to make a property transfer scheme or a staff transfer scheme in connection with the establishment or abolition of a body by the 2012 Act, or the modification of the functions of a body or other person by or under that Act.

Section 90: Abolition of Local Education and Training Boards

This section amends the Care Act 2014 to abolish LETBs.

Section 91: Hospital patients with care and support needs: repeals etc

This amends section 74 and removes Schedule 3 of the 2014 Act. Where a trust is responsible for an adult hospital patient and considers that they are likely to require care and support following discharge, the trust must as soon as it is feasible after it begins making any plans relating to the discharge, take any steps it considers appropriate to involve the patient and any carer of the patient.

Repealing Schedule 3 means that the responsible NHS body can no longer charge the relevant local authority via a penalty notice, where a patient's discharge from hospital has been delayed due to a failure of the local authority to arrange for a social care needs assessment.

Part 2: Health and adult social care: information

Sections 92-101

Summary

The provisions in Part 2 increase data sharing and promote more effective use of data across the health and social care system. Provisions include:

- amending the definition of 'information standards'
- making it easier to compare data across the health and social care system
- sharing anonymous health and social care information
- enabling the Health and Social Care Information Centre (the Information Centre) to require the collection of information from private health care providers
- enabling the secretary of state to require certain providers of adult social care services to provide certain information when requested.

Other provisions include a requirement for the Information Centre to have regard to the need to promote the effective and efficient planning, development, and delivery of health services and of adult social care in England when exercising its functions. There is a new power for regulations to enable the secretary of state to impose a financial penalty on private providers who fail to comply with an information standard. The Medicines and Medical Devices Act 2021 is amended to enable regulations providing for a medicines information system to be established and operated by the Information Centre.

Key sections

Section 95: Information standards

These provisions amend the definition of 'information standards' as set out in the 2012 Act. Information standards set standards relating to processing information, including standards about how information is shared, and which make it easier to compare data, across the publicly funded health and social care system. They are prepared and published by the secretary of state (in relation to health services and adult social care) and by NHS England in relation to NHS services. They apply to the secretary of state and NHS England as well as to bodies involved in the provision of publicly arranged health or adult social care services in England.

Section 96: sharing anonymous health and social care information

This allows a health or social care body to require another health or social care body to provide information, other than personal information, that relates only to its activities in connection with the provision of health services or adult social care in England.

Section 98: Collection of information from private health care providers

This enables the Information Centre to require private providers of health services to provide it with any information it requires in order to comply with a direction from the secretary of state under section 254 of the 2012 Act to establish an information system.

Section 99: Collection of information from adult social care

This section enables the secretary of state to require certain providers of adult social care services to provide to the secretary of state information relating to themselves, their activities in connection with providing adult social care in England, or individuals they have provided adult social care to in England (or, where those services are commissioned by a local authority in England, outside England).

Part 3: Secretary of state's powers to transfer or delegate functions

Sections 102-108

Summary

These sections give the secretary of state powers to make regulations to confer a function on a body, abolish a function of the body, change the purpose or objective for which the body exercises a function, and change the conditions under which the body exercises a function. The functions that may be specified are of the secretary of state's functions which relate to the health service in England or which they may provide for a Special Health Authority to exercise.

Key sections

Section 102: Relevant bodies and Special Health Authorities

The bodies in question here are Health Education England (HEE), the Information Centre, the Health Research Authority, the Human Fertilisation and Embryology Authority (HFEA), the Human Tissue Authority and NHS England.

National context

The government has already announced that HEE will merge with NHS England. The CQC, NICE and the HSSIB are out of scope given their particular and technical regulatory functions.

Section 103: Power to transfer functions between bodies

Regulations under this section may not transfer a function of NHS England if the secretary of state considers that to do so would make NHS England redundant.

Section 104: Power to provide for exercise of functions of Secretary of State

This confers a power on the secretary of state to provide, through regulations, for a relevant body to exercise specified functions of the secretary of state on their behalf.

Section 105: Scope of powers

This sets out the scope of the powers in sections 103 and 104. References in those sections to modifying the functions of a body include abolishing, changing the purpose, or changing the conditions under which the body exercises a function. References to the constitutional arrangements of a body include matters relating to the name, chair and members of the body, the power to employ staff and governing procedures and arrangements.

Part 4: The Health Services Safety Investigations Body

Sections 109 -135; Schedules 13, 14 and 15

Summary

Part 4 of the Act puts the Health Services Safety Investigations Body (HSSIB) on a statutory footing. The organisation was previously established as the Healthcare Safety Investigation Branch (HSIB) under ministerial directions as part of the TDA and hosted by NHS Improvement. Schedule 13 describes the constitution of the HSSIB, including the appointment of the chief investigator and funding. Schedule 14 describes the exceptions to prohibition of disclosure of protected material. Schedule 15 contains consequential amendments relating to Part 4.

NHS Providers view and activity

The government introduced a Health Service Safety Investigations Bill to parliament in 2019. It had undergone pre-legislative scrutiny by a joint committee, and the government responded to its report. We contributed extensively to the joint committee's work, giving oral and written evidence. We also published a comprehensive briefing on the bill, setting out the importance of the HSIB/HSSIB and its contributions to patient safety within the NHS, and our views on a number of key issues, in particular relating to the importance of protecting the integrity of safe space.

When the provisions from that Bill were included as a Part of the Health and Care Bill we were concerned that it would give coroners access to HSSIB protected materials. We raised our concerns each time the Bill was debated and built cross-party support around our proposed amendment which would remove this access. We are very pleased that the government accepted this amendment. We also opposed efforts to extend access to the Parliamentary and Health Service Ombudsman. This will ensure that safe space is sufficiently maintained, allowing those taking part in investigations to share information fully and without fear.

Key sections

Section 109 Establishment of the HSSIB; and Schedule 1

This together with Schedule 13 establishes the HSSIB as a body corporate. Schedule 13 describes the constitution of the HSSIB, including the HSSIB consisting of a chief investigator, executive members, a chair and at least four other (non-executive) members appointed by the secretary of state. The chief investigator is to be appointed by its non-executive members with the consent of the secretary of state. The non-executive must be in the majority and the non-executive members may not appoint more than five other executive

members without the consent of the secretary of state. The HSSIB is funded out of money provided by parliament of such amounts as the secretary of state considers appropriate.

Section 110: Investigation of incidents with safety implications

Section 110 sets out that the function of the HSSIB is to investigate incidents occurring in England during the provision of health care that have or may have implications for the safety of patients (known as 'qualifying incidents'). The purpose of the investigations is to identify risks to patient safety and address those risks by facilitating the improvement of systems and practices. This covers incidents in the NHS or other health care services in England. The purpose of the investigations is not to assess or determine blame, civil or criminal liability or whether a regulatory body should take action in respect of an individual.

Section 111: Deciding which incidents to investigate

Under section 111, the HSSIB determines which qualifying incidents it will investigate, but this is subject to the secretary of state's power to direct the HSSIB to carry out an investigation of a particular qualifying incident or qualifying incidents of a particular description. The secretary of state's directions must be in writing, and may be varied or revoked by subsequent directions, and they may provide for a person to exercise discretion in dealing with any matter. Where the HSSIB discontinues an investigation, it must report that it has done so and give its reasons for doing so. Where the HSSIB determines not to investigate a qualifying incident, it may give notice with an explanation of its determination to anyone it considers to have an interest.

Section 112: Criteria, principles and processes

Section 112 requires the HSSIB to set out, following consultation with the secretary of state and others as considered appropriate, its criteria for determining which incidents it investigates, the principles and processes of investigations, the intended time periods for investigations, and the processes for ensuring patients and their families are involved. The HSSIB's criteria, principles and processes must be reviewed initially after three years, and then every five years.

Section 113: Final reports

The final report of an investigation, according to section 113, must state its fact findings and analysis, make recommendations for any person considered appropriate to action, and set out its conclusions. The report must focus on risks to patient safety and recommendations must focus on addressing those risks (rather than on the activities of individuals involved in the incident). It may not include an assessment or determination of blame, civil or criminal liability, or whether regulatory action in respect of an individual needs to be taken. The report may disclose information which is protected material if the benefits to patient safety outweigh any adverse impact on current or future investigations by deterring people from providing information, and any adverse impact on improving healthcare services. The report may not (without consent) name any individual who gave information to the HSSIB as part of the investigation or who was involved in the incident. The report must be sent to the secretary of state. As per section 114, an interim report may also be published.

Section 115: Draft reports

Section 116: Response to reports

Under section 115, the HSSIB must send a draft report to anyone it reasonably believes could be adversely affected by the report. It may also send a draft to anyone else considered appropriate. Recipients have the opportunity to comment. Section 116 sets out where an interim or final report includes recommendations for any person to action, the HSSIB must share the report with that person and specify a deadline for a written response. In that response, the person must set out the actions they propose to take further to the recommendations. That response may be published by the HSSIB.

Section 117: Admissibility of reports

No draft, interim or final report is admissible in civil or criminal proceedings, any employment tribunal, regulatory proceedings, or in an appeal relating to one of those proceedings. However, the High Court – following an application by a party to the proceedings or someone otherwise entitled to appear in them – may order that an interim or final report is admissible in such proceedings. The HSSIB may make representations to the High Court about any application here. The High Court may make this order only if it determines that the interests of justice served by admitting the report outweigh any adverse impact on current or future investigations by deterring people from providing information, and any adverse impact on improving healthcare services.

Section 118: Powers of entry, inspection and seizure

If considered necessary for an investigation, an investigator may enter and inspect premises (other than private dwellings), inspect and take copies of documents at the premises, inspect any equipment or items at the premises, and remove any document, equipment or other item (unless that would risk patient safety). These powers may be exercised in relation to premises where there is a Crown interest as long as the HSSIB gives reasonable notice. The secretary of state may certify, if in the interests of national security, that powers should not be exercisable in relation to premises with a Crown interest or only in certain circumstances.

Section 119: Powers to require information etc

Section 120: Voluntary provision of information etc

If necessary for the investigation, an investigator may require any person to attend an interview, provide information, and/or – if they are reasonably believed to be able to provide it – provide documents, equipment, or items. However, a person is not required to provide any information, document, equipment, or other item where it would risk patient safety or provision might incriminate the person, or if they would be entitled to refuse to provide that information or document in any court proceedings on the grounds of legal professional privilege. The HSSIB must reimburse the reasonable costs of any person attending to answer questions, and it may record the answers given. A person may also disclose any information, document, equipment, or other item to the HSSIB if they reasonably believe it necessary to enable the HSSIB's investigation function.

Section 121: Offences relating to investigations

It is an offence to intentionally obstruct an investigator or to fail without reasonable excuse to comply with the notice given to attend an interview or to provide information, documents, equipment or other item. It is also an offence to provide information to an HSSIB investigation which is known or suspected to be false or misleading in a material aspect – it is a defence, however, if the person can show they reasonably believed the information would assist the HSSIB, and at the time they informed the HSSIB that they knew or suspected it was false or misleading. An offence here is liable to a fine on summary conviction.

Section 122: Prohibition on disclosure of HSSIB material

This section sets out prohibitions on disclosure of HSSIB material. The HSSIB, or an individual connected with the HSSIB (past or present), must not disclose protected material to any person. 'Protected material' means any information, document, equipment, or other item which is held by the HSSIB or a connected individual for the purposes of the investigation function, and which relates to a qualifying incident, and which has not already been lawfully made public.

Section 123: Exceptions to prohibition on disclosure; and Schedule 14

Section 123 sets out exceptions to the prohibition on disclosure. Prohibitions do not apply to a disclosure which is required or authorised by Schedule 14 (see below), other provisions within Part 4 of the Act, or regulations made by the secretary of state (for example, by reference to the kind of material, the matters to which it relates, the person from whom it was obtained, the purpose for which it was produced or is held, or the purpose for which it is disclosed). Regulations may not require or authorise disclosure of protected materials by reference to the relevant qualifying incident. Regulations may provide for a person to exercise discretion in dealing with any matter.

Schedule 14 describes the exceptions to prohibition of disclosure of protected material. This includes the HSSIB disclosing protected material if:

- it is reasonably believed necessary for the purposes of the carrying out of the HSSIB's investigation function
- the chief investigator reasonably believes it necessary for the purposes of the prosecution or investigation of an offence relating to investigations or to unlawful disclosure
- the chief investigator reasonably believes it necessary to address a serious and continuing risk to the safety of any patient or to the public
- if it is reasonably believed that the person is in a position to address the risk
- if the disclosure is only to the extent necessary to enable the person to take steps to address the risk.

A person may apply to the High Court for an order that any protected material be disclosed by the HSSIB to the person for the purposes specified in the application (which can include onward disclosure). The HSSIB may make representations to the High Court about any application. The High Court may make an order on an application only if it determines that the interests of justice served by the disclosure outweigh: (a) any adverse impact on current

and future investigations by deterring persons from providing information for the purposes of investigations, and (b) any adverse impact on securing the improvement of the safety of health care services provided to patients in England.

Section 124: Offences of unlawful disclosure

A person commits an offence if they knowingly or recklessly breach the prohibition on disclosure and knows or suspects that disclosure is prohibited. Further, a person not connected with the HSSIB to whom protected material is disclosed (in a draft report, in accordance with Schedule 14, or under the section 123 regulations made by the secretary of state) commits an offence if they knowingly or recklessly disclose the protected material to another person without reasonable excuse, and they know or suspect that it is protected material. An offence here is liable to a fine on summary conviction.

Section 125: Restriction of statutory powers requiring disclosure

Powers under any enactment (whenever passed or made) may not be used to require the disclosure of or seize protected material from the HSSIB (or an individual currently or formerly connected with the HSSIB).

Section 126: Co-operation

Where the HSSIB is carrying out an investigation into a qualifying incident and a 'listed person' is also carrying out an investigation into the same or a related incident, they must cooperate regarding practical arrangements to coordinate. Those listed persons are set out and include NHS foundation trusts and trusts, ICBs, NHS England, the CQC, and a number of other statutory bodies. The HSSIB must publish guidance about when a qualifying incident is to be regarded as related to another incident.

Section 127: Assistance of NHS bodies

The HSSIB must comply with any request by a relevant NHS body (such as an NHS foundation trust or trust or an ICB), NHS England or the secretary of state to assist in connection with carrying out an investigation into incidents occurring in the provision of NHS services or at premises providing NHS services. Giving assistance here includes disseminating best practice information, developing standards to be adopted and (unless impracticable) giving advice, guidance, or training. If requested, and as long as it does not interfere with its investigative function, the HSSIB may also give assistance to other bodies (such as independent providers) and charge them for this service.

Section 129: Failure to exercise functions

Section 130: Review

If the secretary of state considers that a significant failure by the HSSIB is occurring or has occurred in the exercise of its functions, the secretary of state may direct the HSSIB to exercise its functions in a specified manner and time period. The secretary of state may not direct the outcome of a particular investigation. If the HSSIB fails to comply, the secretary of state may exercise the functions specified or make arrangements for another person to do so. After four years, the secretary of state must lay before parliament a review into the effectiveness of the HSSIB's investigation function.

Section 131: Offences by bodies corporate

Section 132: Offences by partnerships

Where an offence under this Part is committed by a body corporate and it is proven that an officer of that body has consented or connived in this, or where the officer is negligent, the officer as well as the body corporate commits the offence and is liable. Parallel provisions are made for offences by partnerships.

Section 133: Obligations of confidence etc

Any disclosure of information, document, equipment, or other item which is required or authorised by or under sections 119 or 120 or Schedule 14 do not breach any obligation of confidence owed by the person making the disclosure or any other restriction on disclosure. Nothing within Part 4 of the Bill requires or authorises a disclosure of information which would contravene data protection legislation. When considering whether a disclosure would breach data protection legislation, it should be taken into account that the Bill requires or authorises disclosure.

Section 134 and Schedule 15: Consequential amendments to Part 4

This section introduces consequential amendments through Schedule 15.

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Part 5: Virginity testing and hymenoplasty offences

Chapters 1 & 2, Sections 136 -160; and Schedule 16

Summary

These provisions create a number of offences and penalties relating to virginity testing and hymenoplasty in the UK. This includes an offence of virginity testing, offering to carry out virginity testing, or aiding or abetting a person to carry out virginity testing.

Part 6: Miscellaneous

Sections 161-181; Schedules 17, 18 and 19

Summary

Part 6 covers a range of issues including:

- establish a cap on adult social care cost contributions
- enable the secretary of state to intervene in the event of a local authority failing in its provision of adult social care
- create a duty for the CQC to inspect adult social care
- the appointment of medical examiners
- require the secretary of state to arrange for a review into disputes relating to treatment of critically ill children
- mandatory training on learning disability and autism
- enable changes to be made to the professional regulation system
- set minimum standards for food and drink in hospital settings.

Sections here also:

- require the secretary of state to report on the government's information sharing policy for purposes relating to child safeguarding or children's health or social care
- maintain the provisions for at-home early medical termination of pregnancy
- enabling regulations to allow more products to be centrally stocked and supplied free of charge to community pharmacies
- restrict the advertising of certain food and drink products
- ensure informed consent with no coercion or financial gain for the donation of organs
- lengthen the storage time for gametes and embryos
- prohibiting unlicensed cosmetic procedures
- provide for implementation of more comprehensive international reciprocal healthcare arrangements
- make regulations regarding food information and labelling
- introduce powers for the secretary of state to introduce, terminate or vary water fluoridation schemes.

Key sections

Section 163: Regulation of local authority functions relating to adult social care
This section sets out a duty for the CQC to conduct reviews, assess performance and publish reports on the exercise of regulated care functions by English local authorities relating to adult social care.

The secretary of state will set objectives and priorities for the CQC's assessments. The CQC is required to determine indicators of quality to assess local authority performance and prepare a statement setting out the frequency of reviews and a methodology for assessing local authorities' performance, with flexibility to set different indicators, objectives, and priorities for different cases. The secretary of state has powers to direct the CQC to revise its quality indicators, assessment framework, and frequency and methodology for different cases.

NHS Providers view and activity

We sought and received reassurances from the government on the floor of the House that these powers will be used infrequently by the government so as not to disrupt CQC reviews. They also affirmed that the government will fully respect the independence of the CQC.

Section 166: Cap on care costs for charging purposes

This establishes a cap on the amount that adults can be required to pay towards eligible care costs over their lifetime. The government has indicated these provisions will be commenced in October 2023.

Section 167: Provision of social care services: financial assistance

This enables the secretary of state to give financial assistance to bodies engaged in social care provision or connected services. The secretary of state may direct an NHS trust or an SpHA to exercise any of the functions of the secretary of state in relation to this financial assistance.

Section 168: Regulation of health care and associated professions

This section enables changes to be made through secondary legislation to the professional regulation system. It also permits a currently regulated profession to be removed from statutory regulation when the profession no longer requires regulation for the purpose of the protection of the public. It also provides an updated list of the legislation that regulates professions. The section clarifies that a profession is to be treated as including 'any group of workers', whether or not they are generally regarded as a profession, indicating that senior managers and leaders could be considered as part of these provisions.

Section 169: Medical examiners

This section amends the Coroners and Justice Act 2009 in England and allows for NHS bodies, rather than local authorities, to appoint medical examiners. This means that every death in England and Wales will be scrutinised either by a coroner or by a medical examiner. It also introduces a duty on the secretary of state to ensure that:

- enough medical examiners are appointed in the healthcare system in England
- enough funds and resources are made available to medical examiners to enable them to carry out their functions of scrutiny to identify and deter poor practice

- medical examiners' performance is monitored by reference to any standards or levels of performance that they are expected to attain.

The section also introduces a power for the secretary of state to give a directions to an English NHS body in order to:

- require the body to appoint one or more medical examiners
- set out the funds or resources that should be made available to a medical examiner
- set out the means and methods that may be employed to monitor performance of a medical examiner.

These sections do not give any English NHS body any role in relation to the way in which medical examiners exercise their professional judgment as medical practitioners.

Section 171: Storage of gametes and embryos; and Schedule 17
Amends provisions in the Human Fertilisation and Embryology Act 1990 pertaining to the storage of gametes and embryos.

Section 172: Advertising of less healthy food and drink; and Schedule 18
Schedule 18 amends the Communications Act 2003 to restrict the advertising of certain food and drink products.

Section 173: Hospital food standards
This section provides for regulations to be made to set minimum nutritional standards for food and drink provided in hospital settings.

NHS Providers view and activity

During the passage of the Bill, we impressed on the government the need to consult trusts, foundation trusts and ICBs when drafting regulations on food standards. We secured ministerial assurances (col 338) on the floor of the House that they will continue to use existing legal powers and obligations to engage with trusts, the food standards and strategy group, and the NHS food review expert group through the NHS food review.

Section 177: Review into disputes relating to treatment of critically ill children
This section requires the secretary of state to arrange for the carrying out of a review into the causes of disputes between (on the one hand) persons with parental responsibility for a critically ill child and (on the other) persons responsible for the provision of care or medical treatment for the child as part of the health service in England. A report on the outcome of the review must be published and laid before parliament.

Section 180: Licensing of cosmetic procedures; and Schedule 19
The section empowers the secretary of state to make regulations to establish a licensing regime in connection with non-surgical cosmetic procedures.

Section 181: Mandatory training on learning disability and autism
This amends the Health and Social Care Act 2008 so that regulations under section 20 of that Act must require service providers to ensure that each person working for the purpose of the regulated activities carried on by them receives training on learning disability and autism which is appropriate to the person's role. The secretary of state must issue a code of practice about compliance with requirements imposed by virtue of these new provisions.

National context

Section 172 and Schedule 18 (advertising of less healthy food and drink) will come into force on 1 January 2024 following a delay announced by the government on 17 May 2022. As part of the May 2022 Queen's Speech the government indicated that the social care cap will come into force in October 2023.

Part 7: General

Sections 182-186

Summary

This part allows the secretary of state, by regulations, to make provision that is consequential on this Act. Where regulations modify primary legislation, the affirmative procedure must be used (meaning they must be actively approved by both houses of parliament). Otherwise, regulations can be made under the negative procedure. Regulations made under the negative procedure becomes law on the day the minister signs them and automatically remains law unless a motion – or 'prayer' – to reject it is agreed by either House within 40 sitting days.

Key sections

Section 186: Commencement

Most provisions of the Act will come into force on the day or days specified by the secretary of state in regulations, other than Part 7 (dealing with consequential amendments, regulations, extent, commencement, and the Act's title) which came into force on 28 April 2022. Exceptions are set out in section 186.

Schedules

Schedule 1 (Section 1) – Renaming of NHS Commissioning Board

Schedule 2 (Section 19) – Integrated care boards: constitutions etc

Schedule 3 (Section 22) – Conferral of primary care functions on integrated care boards etc
Part 1 – Conferral of functions etc
Part 2 – Consequential amendments

Schedule 4 (Section 32) – Integrated care system: minor and consequential amendments

Schedule 5 (Section 33) – Abolition of Monitor and transfer of its functions

Schedule 6 (Section 46) – Intervention powers over the reconfiguration of NHS services

Schedule 7 (Section 50) – NHS trusts in England and removal of power to appoint trustees: consequential amendments

Schedule 8 (Section 70) – Trust special administrators: NHS Trusts and NHS foundation trusts
Part 1 – Amendments about trust special administrators
Part 2 – Consequential amendments

Schedule 9 (Section 72) – References to functions: treatment of delegation arrangements etc

Schedule 10 (Section 77) – The NHS payment scheme

Schedule 11 (Section 78) – Patient choice: undertakings by integrated care boards

Schedule 12 (Section 84) – Removal of functions relating to competition etc

Schedule 13 (Section 109) – The Health Services Safety Investigations Body
Part 1 – Constitution
Part 2 – Transfer schemes

Schedule 14 (Section 123) – Prohibition on disclosure of HSSIB material: exceptions

Schedule 15 (Section 134) – Consequential amendments relating to Part 4

Schedule 16 (Section 160) – Virginity testing and hymenoplasty: consequential amendments

Schedule 17 (Section 171) – Storage of gametes and embryos
Part 1 – Amendments to Human Fertilisation and Embryology Act 1990
Part 2 – Transitional provision

Schedule 18 (Section 172) – Advertising of less healthy food and drink
Part 1 – Programme services: watershed
Part 2 – Online services: prohibition
Part 3 – Consequential amendments
Schedule 19 (Section 180) – Licensing of cosmetic procedures

4 THE DEVELOPMENT OF THE ACT

The purpose of the Act is to give effect to the policies that were set out as part of the NHS's recommendations for legislative reform following the NHS long term plan and in the white paper 'Integration and Innovation: Working together to improve Health and Social Care for all' published in February 2021.

Throughout the development of the legislative proposals and subsequent Bill, we drew on the insights and expertise of NHS trusts and foundation trusts, and we engaged extensively and constructively with DHSC, NHS England and NHS Improvement, health and care stakeholders and parliamentarians. Below we summarise how the Act developed, and our work to influence and improve it in support of members, communities and the wider system.

September 2019
A limited set of proposals for legislative changes were brought forward by NHS England and NHS Improvement in autumn 2019 and we published a thorough analysis in an On the day briefing.

February 2021
White paper published. We published a comprehensive On the day briefing. We also submitted written evidence to the health and social care committee's inquiry into DHSC's white paper and gave oral evidence to the committee on 2 March 2021.

July 2021
The Health and Care Bill was published in parliament. Our On the day briefing analysed the Bill, highlighting those areas where we wanted to see changes to the legislation. The Second Reading of the Bill was held in the House of Commons on the 14 July. We published a briefing ahead of this debate.

September 2021 – November 2021
The House of Commons set up a general committee on the Health and Care Bill to scrutinise the Bill in depth. It took evidence from key stakeholders, including NHS Providers. We submitted written evidence and also gave oral evidence.

We provided numerous briefings throughout committee stage in the House of Commons which can be found here. This stage of the Bill was completed on the 22 November 2021 and followed by Report Stage in the House of Commons on the 22 and 23 November.

December 2021
The Bill had its Second Reading in the House of Lords in December 2021. We produced a briefing ahead of this debate, highlighting changes that happened during Committee stage in the House of Commons and where we thought improvements could still be made to the legislation.

January – March 2022
The House of Lords scrutinised the Bill at Committee stage. We produced a number of briefings on key amendments during this stage of the Bill.

March 2022

Report Stage and Third Reading of the Health and Care Bill took place during March. We published a briefing ahead of Report Stage as well as a joint statement with key stakeholders.

April 2022

Consideration of Commons amendments and consideration of Lords amendment ('ping-pong') took place throughout April 2022, prior to the Bill receiving Royal Assent and becoming the Health and Care Act 2022 on 28 April.

Suggested citation

NHS Providers (July 2022),
A guide to the Health and Care Act 2022 for trusts and foundation trusts

Interactive version

This report is also available in a digital format via:
www.nhsproviders.org/a-guide-to-the-health-and-care-act-2022

Trusts IN SYSTEMS

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 foundation trusts and 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 England in voluntary membership, collectively accounting for £104bn of annual expenditure and employing 1.2 million staff.

NHS Providers

One Birdcage Walk, London SW1H 9JJ
020 7304 6977
enquiries@nhsproviders.org
www.nhsproviders.org
@NHSProviders