Wirral Community Health and Care NHS Foundation Trust

Chair's Report - August 2021

I am pleased to provide a written report to the Board of Directors which covers some key updates for members' attention and assurance.

Resetting governance arrangements

As we restart our services, we are transitioning from emergency governance arrangements to enhanced extant arrangements.

The opportunity to reflect on the success of the emergency arrangements, particularly the efficiency, focus and collaborative approach that has resulted, has provided us with an opportunity to refine and strengthen for the future.

Consequently, we have revisited our governance arrangements to streamline our processes and we have considered this in the context of the organisational design programme to ensure effective information flows and assurances at every level, the priorities of the Trust workplan for 2020-21, the requirements of the new CQC strategy and the anticipated requirements of the NHS reforms including a new Single Oversight Framework.

A more detailed overview of the new arrangements including the proposed performance framework is included at agenda item 15.

The sub-committees of the Board have now all re-established and, in the context of the new governance arrangements, all terms of reference are being reviewed and will be brought together for approval to the Board of Directors meeting in October 2021. The Chairs of the committees will provide an update on the recent meetings held on today's agenda.

Informal board programme 2021-22

The Board of Directors met in informal session at the beginning of July and a briefing of the topics discussed is included at agenda item 16. We also discussed and agreed the proposed Informal Board Programme for 2021-22 which will be presented for formal approval today.

The value of these informal sessions is recognised by all members of the Board and the opportunity to re-establish a forward-looking programme is welcome.

Well Led developmental review

At our next informal board meeting, we will be revisiting the learning identified from our internal well-led developmental review, completed in late 2019/early 2020.

As previously reported the final action planning stage was suspended in March 2020 due to the Trust's response to COVID-19. However, we recognise that the value of the learning is still important.

To further enhance and strengthen this learning and to recognise the different environment in which all NHS Trusts are now operating, and the new ways of working adopted, the Board of Directors will be commissioning an external review of well-led to further test systems and processes in place against the NHSI and CQC well-led framework.

It is anticipated that this piece of work will commence in the early autumn.

Council of Governors

As reported by Bill Wyllie, Lead Governor we have continued to meet with our Council of Governors both in formal and developmental sessions. Bill's report provides a useful summary of the topics being discussed with our governor colleagues.

Cheshire & Merseyside Integrated Care System (ICS)

I would like to extend my personal thanks and best wishes to Alan Yates, Chair of the Cheshire & Merseyside HealthCare Partnership as he leaves his post from 1 August 2021 and offer my support and commitment to David Flory as he assumes the role of ICS Chair on an interim basis.

Healthy Wirral

I continue to participate actively and represent the Trust in the Healthy Wirral programme of work and in a range of regional and national fora. I appreciate valuable and productive discussions with Chair colleagues across the system.

It is a challenging and interesting "planning" environment to try within which to make progress. We have a "shadow" Integrated Care System (ICS) for Cheshire and Merseyside, now operating with an interim Chair and an interim CEO that has to develop itself into a corporate body with full functionality by April 2022. This assumes the Act of Parliament which will create this body is fully enacted: currently the Bill has been given a parliamentary second reading and Royal Assent is not anticipated until February 2022.

At a Wirral level a lot of collaborative work to bring all partners together to establish a local Integrated Collaborative Partnership (ICP) is moving forward, although not helped by continuing uncertainty about the likely level of delegations from the ICS and the rules of engagement. The approach being adopted is to agree ideal arrangements to serve the residents of the Wirral in dealing with the delivery of integrated services and tackling health inequalities, whilst recognising that these arrangements might need to be adjusted at a later stage when firm regulation and authority mechanisms are fully defined.

Finally, my thanks to Beverley Jordan, Non-Executive Director and Deputy Chair who will be chairing the Board of Directors meetings on my behalf this month.

I invite the members of the Board of Directors to receive this report for information.

Professor Michael Brown CBE DL
Chair

28 July 2021

Wirral Community Health and Care NHS Foundation Trust

Lead Governor Report

Since the last meeting of the Board of Directors, the Council of Governors met formally on 14 June 2021 and informally at a development session on 26 July 2021.

I therefore provide a summary of the items discussed at each of these meetings for Board noting.

Formal Council of Governors meeting - 14 June 2021

The governors came together with members of the Board of Directors to consider a lengthy agenda providing important updates on both national, regional and local developments.

Following a series of questions raised by governor colleagues, Karen Howell, Chief Executive and Michael Brown, Chairman provided an update on the implications of the White Paper for WCHC and the wider Wirral health and care system. This included consideration of the local approach to integration, the impact of the proposed reforms on domiciliary care services and care homes, patient involvement and the scale and scope of the Cheshire & Merseyside Integrated Care System.

It was appreciated by governor colleagues that both Karen and Michael shared available information and provided useful context on the developments locally and regionally, but it was also recognised that much uncertainty exists as the Bill travels through Parliament. It was noted that further updates in this regard would be provided to governors, including informally through development sessions, as it would be important to allow governors to actively contribute to the development of the Trust's forward plans and 5-year strategy.

A presentation on the Trust's workplan for 2020-21 was provided by Tony Bennett, Chief Strategy Officer, providing governor colleagues with an overview on the priorities of the Trust in four key areas including; People, Quality, Operations and Investment.

Further updates provided for assurance included an overview of the new CQC strategy, and the Trust's development of the new Marine Lake Health & Wellbeing Centre.

In line with the duties of the Council of Governors, Alison Hughes, Director of Corporate Affairs provided a briefing on the procurement process to appoint external auditors for the Trust. This followed previous approvals at the formal meeting in January 2021 and reflected the commencement of the procurement process which governors will lead supported by the Audit Committee.

Each of the Non-Executive Directors of the Board provided a useful update on the business of their committees reflecting the transition from emergency to extant governance arrangements across the Trust. The Chair of the Governor Quality Forum, Veronica Cuthbert, public governor for Wirral South also provided an assurance report following a briefing from the Chair of the Trust's Quality & Safety Committee, Professor Chris Bentley.

Council of Governors development session - 26 July 2021

The agenda for the development session was proposed by the Trust with input from governor colleagues on topics for discussion. The intention of the development sessions is that of learning, discussion and exchanging ideas with no formal approvals sought.

The agenda was again lengthy, and some reflection post-meeting suggests that together the Trust and governors will review the scope and purpose of such sessions to ensure that appropriate and relevant information can be discussed and debated.

A useful session on the Quality Strategy was provided with a specific focus on the Engaged Populations priority and the Trust's progress to enhance the Your Experience programme of work to increase opportunities for patients and service users to give and received feedback. Julia Bryant, Quality Lead joined the session to share this information with governors and invited further involvement and sharing of views. The role of the Your Voice group (attended by governors with a membership consisting of public members of the Trust) was highlighted as important in this area to support co-production across Trust services. The new Patient Experience volunteer roles was also discussed with great interest and useful ideas and suggestions shared by governor colleagues.

Following the formal update on the new CQC strategy at the last meeting of the governors, Paula Simpson, Chief Nurse joined the development session to brief governors on the Trust's programme of work to ensure CQC compliance and readiness particularly in the reset and restart of Trust services. The new inspection regime was highlighted with governors invited to share views and seek any clarification. It is anticipated that CQC compliance will remain a key topic for future governor development sessions.

An update on the reset of governance arrangements (on today's agenda) was also shared with governor colleagues providing an opportunity to describe the information and assurance flows through the organisation and to clearly position the Council of Governors as part of Trust governance.

The challenges of waiting list management in the restart of services was discussed with the Trust providing an overview of the systems and processes in place to effectively manage waiting lists across Trust services. It was recognised that there were challenges, but patient safety and equity of access remained at the heart of the approach being taken. Val McGee, Chief Operating Officer joined the session and together with Beverly Jordan, Non-Executive Director provided some clarity to governor questions and concerns.

Finally, Tony Bennett, Chief Strategy Officer and David Hammond, Deputy Director of Strategy joined the session to share the engagement plan to develop the Trust's 5-year strategy. It was recognised that governors will be key stakeholders in this programme of work given our role to represent the views of members and members of the public, hence a useful briefing for all. All governors present expressed their interest to participate in this work and further questions on the impact of the NHS reforms were considered and a specific question from our Rest of England governor, Jan Gidman on the implications for contracts outside of Wirral. It was useful to hear from the Trust that the development of the 5-year strategy will be informed by the latest and best information available about C&M ICS intentions about contractual relationship with Provider Collaboratives working across the ICS.

The governors will hold another development session in November 2021 and an item for discussion on the People Plan has been agreed. Some governors have expressed a wish to explore the way in which, while receiving strategic briefings and assurances from Trust senior management, they may seek to provide feedback from public constituents on the delivery of services by the Trust. In that way, and whilst not seeking to become involved in operational

or tactical matters, they would wish both to inform the Trust and to receive responses that may clarify ongoing positions.

Your Voice Group

The Your Voice group met virtually on 22 July 2021 with governor colleagues in attendance. There were useful discussions on the restart of Trust services and the future focus of the group as part of the Quality Strategy Engaged Populations workstream.

I provide this report to the Board of Directors for noting and assurance on the work of the Council of Governors.

Bill Wyllie
Lead Governor (public governor, Wallasey)

29 July 2021

Wirral Community Health and Care NHS Foundation Trust

Chief Executive's Report - August 2021

1. I present this report to the Board of Directors providing an update on regional and local news and developments including important updates from across the Trust and an overview of the work considered by the Executive Leadership Team. I also highlight some key national updates for information.

Regional and local news and developments

NHSE/I Regional Director, North West

2. NHS England and NHS Improvement has confirmed the appointment of Dr Amanda Doyle, current Chief Officer of Lancashire and South Cumbria ICS, as the new Regional Director for the North West. Amanda will replace Bill McCarthy, who retired as Regional Director at the end of July.

3. As a GP who has spent over 20 years serving some of the most deprived parts of Blackpool and with extensive experience working in national and regional leadership roles across the North West, Amanda brings with her a wealth of insight that will be invaluable as we move into the next stage of our response to COVID-19 and beyond.

4. Amanda will start her new role in August 2021.

Cheshire & Merseyside Health and Care Partnership

5. Following the previous announcement that both Jackie Bene and Alan Yates will not continue in their roles of Chief Officer and Chair for the HCP, it has now been confirmed that Alan will leave his role on 1 August 2021 and David Flory, Chair of Lancashire and South Cumbria ICS will be Acting Chair for the ICS whilst a permanent appointment is secured as part of the national recruitment process.

6. David will work with all partners to ensure the ICS has continued, strong leadership to deliver the commitment to provide integrated care across Cheshire and Merseyside. It is anticipated that this appointment will be for a minimum of three months and David will also continue his role at Lancashire and South Cumbria ICS.

7. Due to there being a national process for Chief Officer appointments to all ICS's and the lack of a substantive Chair for Cheshire & Mersey, an interim arrangement has been agreed with Sheena Cumiskey from CWP acting in to the Chief Officer for 3 months to ensure continuity.

8. The Cheshire & Merseyside CEO Provider group has established a task and finish group to look at system pressures, and the formation of Provider Collaboratives across Cheshire & Merseyside.

9. The Memorandum of Understanding for the Cheshire & Mersey Mental Health, Learning Disability and Community Provider Collaborative (formerly C&M Out of Hospital CEOs) has been drawn up and approved by the Boards of member organisations.

Wirral - Integrated Care Partnership

10. The leaders across Wirral continue to come together under the Healthy Wirral Partnership Board umbrella to ensure continuity and improvement of service provision across the system.

11. The Board has received regular updates on the ICP development work and the planned workstreams in Ophthalmology, Dermatology and Medicines Management.

12. Following recent discussions, the system CEOs have agreed that the ICP Chief Executive sponsor(s) will be jointly held by Janelle Holmes, Chief Executive Officer WUTH and myself.

13. The Board is working in earnest to build and establish its governance infrastructure for the new Integrated Care partnership (ICP). This work is being led by an ICP Delivery Group consisting of senior leaders from across NHS and other statutory bodies. On 27 July 2021, an ICP workshop was held with all Chief Executives which was a successful start to the development of the ICP for Wirral. Representation from across primary and secondary NHS services and the independent charitable and faith sectors was present. Following this event, it has been agreed that there will be one more event specifically of this kind, focusing on the Provider Collaborative unique selling point (USP) and construct including membership. Furthermore, there will be a number of other workshops over the next few months focusing on governance and full ICP build. However, at the time of reporting we are still awaiting further guidance.

14. Under the leadership of the system Chief Executive Officers, it has been agreed that a joint system response to the national COVID Inquiry will be led by the Director of Public Health.

Health and Wellbeing Board (HWBB)

15. The Health & Wellbeing Board in Wirral has been re-established and I was pleased to be able to join the first meeting at the Floral Pavilion in July 2021.

Shaping Our Future - Developing Plans on a Page

16. Since the launch of our 2021-22 workplan our services have been working hard to develop their Plans on a Page and agree on their priority areas for the coming year. This has been an important task and I am delighted that we have received positive feedback from many teams on the opportunity to spend time together and influence service delivery and priorities.

17. To support the development of local Plans on a Page, Executive colleagues held drop-in sessions during early July to provide an opportunity for staff to seek advice, guidance and to share ideas and plans.

Our common purpose and NEW values

18. We were pleased to launch our new Trust values in early July 2021 to coincide with the NHS 73rd birthday. These values reflect the voice of our workforce and what they want for the future of the Trust as we have developed them together over the last 6 months.

19. The three words; Compassion, Open and Trust each have a supporting statement and will guide very aspect of what we do in the future.

    Compassion - supportive and caring, listening to others

    Open - communicating openly, honestly and sharing ideas

    Trust - trusted to deliver, feeling valued and safe

20. Our common purpose is clear, that '**together we will support you and your community to live well**,' working collaboratively, and inclusively as one team.

21. Over the coming weeks and months this common purpose and our values will become embedded in our work, our processes and our culture. They will become part of our everyday narrative as we work together to deliver services to our communities across Wirral, Cheshire East and St Helens.

22. Most importantly, we will be asking our workforce, how they want to use the values to make positive change and ensure they are not simply words on a page.

23. I would like to extend my thanks to the wider team from Learning & Development, Communications and Business Strategy for leading this exciting piece of work and also to every single member of staff that took the time to get involved, to share their feedback and their vision for the future and help us refresh our values.

Our response to COVID-19 and service recovery

24. As a Trust we continue to respond to the challenges of the COVID-19 pandemic supporting our patients and service users to access the services they need where and when they need them. Whilst our primary focus is now on the restoration of our services, we continue to support the local hospital to ensure swift and safe discharges to ensure it maintains capacity for those most vulnerable in our community and that people receive the care they need.

25. All staff previously reassigned to other services across the Trust have now returned and systems and processes, aligned to regional and national guidance are in place to ensure the appropriate clinical triage of patients and service users seeking to access our services. The full recovery and restart of services to a business as usual state is underway and ensures that action plans are in place for services that now have extended waiting lists and clinically prioritised and appropriate access to front-line services.

26. Our priority is to ensure our services are restored equitably whilst also responding to the inevitable health inequalities that have emerged as a result of the pandemic.

27. In mid-July as COVID-19 public restrictions were lifted by the Government - a day badged as *'Freedom Day'*, ALL existing safety measures remained in place at the Trust and across the whole of the NHS. There is no change to NHS England and Public Health England's existing infection prevention and control guidelines.

28. We are ensuring our staff to carry on following the guidance, to ensure a safer environment for everyone and to reduce the risk of infection. Our staff right across the Trust are continuing to observe all existing safety measures; wearing face masks in all areas around the Trust, maintaining 2 metre social distancing, wearing PPE when needed, washing your hands thoroughly and more often, and continuing to Lateral Flow Test twice a week.

29. We are asking our patients and service users to follow all existing safety measures when accessing our services across our estate. Our priority is to keep each other, our patients and service users safe.

30. Our duty of care to our staff remains a priority and their individual and collective health and wellbeing has been an important focus of our staff support over the last 12 months. The new monthly NHS People Pulse survey provides an opportunity for a regular temperature check with our workforce to determine where extra support might be required.

31. Our mandatory training compliance continues to be strong and at the end of June 2021 we were reporting 92.3% compliance. Our staff sickness levels also continue to be well managed and in line with the Trust's target of 5%; this is testament to the hard work, dedication and commitment of our workforce, and the support of managers.

32. The Trust continues to operate within the national emergency funding arrangements and remains on track to achieve the H1 plan previously approved by the Board of Directors. Guidance on H2 funding arrangements is not expected until September 2021 although the Trust is already planning for an increased waste reduction requirement (previously referred to as the efficiency requirement) in the second half of the current financial year.

33. We are not currently being assessed against the Use of Resources performance requirements by NHS Improvement and as a result of COVID-19 our Cost Improvement Programme savings plans remain on hold and under review.

Resetting our governance arrangements

34. Following the establishment of emergency governance arrangements during 2020-21 to support an effective response to the COVID-19 pandemic, we are now re-establishing new and extant governance arrangement that both ensure appropriate assurance and

information flows through the organisation but also learn from the new ways of working and streamlined approaches adopted during the response to COVID-19.

35. Further information is included at agenda item 15 on the meeting agenda.

36. As part of our extant arrangements, we continue to track the quality and safety of the care we provide through established indicators, including risk and incident management. Our Quality & Safety Committee meets on a bi-monthly schedule.

37. The Education & Workforce Committee and the Finance & Performance Committee have also continued to meet according to the their extant bi-monthly schedule following their re-establishment in April and May respectively.

Community Intermediate Care Centre

38. The Trust has secured a two-year contract for the Community Intermediate Care Centre (CICC) on the Clatterbridge Hospital site, and we will be opening a further two wards in addition to Bluebell Ward - Iris Ward and Aster Ward.

39. Community beds are part of community services and through their hard work, commitment and collaborative working, our team has shown throughout the pandemic that we are best placed to deliver this service. Thank you to the team who have worked incredibly hard to make this happen.

40. We look forward to opening the Iris and Aster wards in September 2021.

COVID-19 vaccination programme

41. I can report that the uptake of the first COVID-19 vaccine is at 91% across the workforce, with 96% of those staff also having received the second vaccine.

42. We are also actively encouraging all staff to continue to complete Lateral Flow Testing.

43. Together with system partners, we are also assertively targeting the younger population (aged 19-25 years) to receive the COVID-19 vaccine.

Patient Experience Volunteers

44. A key priority in our Quality Plan for 2021-22 is Engaged Populations and embedding an inclusive approach which promotes the rights, strengths and wellbeing of people, families and communities. There is a wealth of work in progress across the Trust to support this priority all of which is being tracked through our SAFE steering group and overseen through the Quality & Safety Committee.

45. In support of this we have recently launched a new Patient Experience Volunteer role and we are delighted that six of existing Trust volunteers have agreed to take this role working directly with services to engage with service users over the phone to seek their feedback on their experience of the care and service they received.

46. The response we have had so far from services and the volunteers is very positive and we look forward to seeing this role grow further.

Leading Self on-line masterclasses

47. True leadership comes from understanding ourselves, drawing upon our values, principles and strengths to deliver high standards of care, taking responsibility for the choices we make and being aware of the impact we have on others. Only when we truly understand ourselves are we able to be great leaders.

48. We were delighted to welcome Ed Hollamby, keynote speaker, presenter and coach back to the Trust in July to run a series of leading self-masterclasses available to ALL staff across the Trust.

49. These masterclasses were motivating, inspiring, encouraging and challenging and purposefully linked to four key themes from the most recent NHS Staff Survey: health and wellbeing, team working, morale and quality of care.

50. They aimed to provide attendees with powerful and effective tools to weave into work and personal life and were structured around three key areas;

    - **Session one: Selfcare isn't selfish!**
      The importance of self-care and taking positive actions for health and wellbeing

    - **Session two: Mindsets matter - massively**
      Learning how to respond instead of reacting to life's events - focusing on how to achieve this as an individual as well as a team

    - **Session three: Hippo time is ok**
      Developing strategies to move forward in both personal and professional lives following the global pandemic

51. The feedback from these masterclasses has been wonderful with so many staff taking the time to either attend live or catch up with the videos on Staff Zone. This demonstrates our commitment to support our workforce in their health and wellbeing recognising the demands and challenges they respond to every day caring for our local communities.

Information Governance Awareness Week

52. We held Information Governance Awareness Week across the Trust from 12-16 July 2021 providing an opportunity to highlight the importance of information and how it is everyone's responsibility.

53. IG week was hosted by Alison Hughes, Director of Corporate Affairs and Trust SIRO and during the week we reflected on the many ways' services and teams across the Trust have adapted to a predominantly digital way of working over the last 18 months, supported by robust IG processes.

54. The week-long awareness campaign shared top tips for maintaining high IG standards, with a special focus on sending secure e-mails and record keeping.

55. We also celebrated the sustained strong performance across the Trust for the mandatory Data Security Awareness training with 82% of staff having completed it already this financial year.

Team Time Schwartz Rounds

56. We are delighted to have launched the first in a series of team time Schwartz Rounds at the end of July 2021. Working with the 'Point of Care Foundation' the Trust has invested in the programme which is widely used across the NHS.

57. Schwartz Rounds provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare.

58. The theme of the first team time Schwartz Round is 'COVID and Me'. I look forward to receiving feedback on this and future sessions and my thanks to those facilitators who are delivering the sessions.

BAME Network event - Rising Through the Ranks

59. The Trust's BAME staff network hosted a successful Rising Through the Ranks event in mid-July with over 80 attendees from across the Trust, partner organisations and members of our NHS Cadets alumni.

60. The online event aimed to inspire, inform and challenge colleagues to make progress in their career through sharing individuals' stories from within the NHS. The feedback from the event has been extremely positive and my thanks and congratulations are extended to all members of the BAME network, particularly the network Chair Yinka Koomson and other colleagues who supported the event and shared their stories. I look forward to future events hosted by this and other staff networks.

Congratulations!

61. We recently received our Practice Assessment Record and Evaluation (*PARE - definitive healthcare practice placement quality monitoring tool)* quality quarterly report which provided the Trust with an overall score of 98.59%. This is a 1.5% improvement on the last report, and we continue to achieve a score above the regional average.

62. Thank you to everyone involved, together we are ensuring we have a workforce to deliver healthcare in the future.

ISO14001:2015 Sustainability Award

63. I am delighted that we have successfully retained the prestigious Sustainability Award (ISO 14001:2015) for the fourth year running, and this year we included another two buildings which means that all Trust owned properties have now been assessed.

64. In order to achieve the award, the Trust must continually improve environmental performance to ensure sustainability and reduce environmental impact of activities, products and services. It helps improve environmental performance through more efficient use of resources and reduction of waste.

65. My thanks to everyone involved in securing this award for the Trust.

HSJ Patient Safety Awards - we made the shortlist!

66. I am delighted to announce that two Trust projects have been shortlisted at this year's HSJ Patient Safety Awards, recognising their outstanding contribution to healthcare. Following one of the toughest years in health and social care, we continue to champion patient safety amidst challenges that the sector is facing.

67. The Integrated Therapy Review initiative has been shortlisted for 'Improving Care for Children and Young People Initiative of the Year' and the IPC Care Home Project has been shortlisted for the 'Covid-19 Infection Prevention and Control Award'.

68. I am also delighted that the Picker Institute has published an Always Event ® case study on their website on the Integrated Therapy Review initiative - https://www.picker.org/always-events

69. I am proud to share below some highlights from the shortlisted submissions.

Integrated Therapy Review

70. The Integrated Children's Division recognise the significant impact the global pandemic has had on children's ability to access specialist services, leading to a potential delay in children meeting developmental milestones and the longer-term impact of them not accessing their usual therapy appointments. Many children have been affected, but more so those children with complex health needs.

71. Through on-going engagement processes and prior to the pandemic, the team already understood the complexities families face in managing the number of health appointments for children, as well as the challenge in navigating the numerous NHS organisations and providers.

72. The team were also aware of the requirement to continue to provide statutory health appointments for children with Education, Health and Care Plans (EHCPs)

73. Their aim was to provide tailored, individual and safe care to these children and developed a multi-agency task and finish group to identify the safest and most effective way to do this, given that a lot of the children were shielding.

74. The aims were therefore to;

- reduce the number of appointments for children
- provide safe care
- provide continuity of care
- develop a coordinated therapy care plan, including outcome measures
- improve waiting times for patients
- utilise digital ways of working to support

75. The approach led to the pilot of an integrated therapy review. Thirty families were initially identified to take part and the team were overwhelmed with the response as each family said yes. The team explained that this would not replace individual or specialist therapy from services, but enabled families to access a multi-agency appointment and agree a plan of care together, allowing them to share their experiences and concerns once.

76. In order to assess the progress of the improvement, families were asked to complete an initial questionnaire based on their experiences of each service. The plan was to focus on internal services first, with the intent to roll out to external services.

77. The anticipated outcome was to enhance quality of life for people with long-term conditions;

- Through monitoring and management of individual outcome measures for each child, within their care record, has allowed the team to manage the effectiveness of the interventions provided by each service.
- Development of a '*Therapy Outcome Measure'* dashboard for longer term monitoring and service planning.
- The development of an integrated records template which sits across numerous SystmOne units, allows the lead health professional to pull together one individual care plan and report for the child, which can be sent to GP, school and other professionals involved in the child's care.
- The team has also been able to offer consistency and support to families through virtual platforms, where children have not been able to access support through schools or in clinic settings.

78. The review has enabled the practitioners to engage with families in a holistic way and find out what matters to parents/carers and their child. The voice of the child has been considered and if possible and appropriate the practitioners have engaged with the child directly over the virtual platform.

79. The team has received lots of positive feedback, which evidenced improvements in their experiences, including:

"*Good idea will save family time reducing number of appointments they have to attend. Found the clinic useful*" (Foster Parent)

"*Found clinic useful and feels it will reduce number of appointments family have to attend*" (Mum)

"*Great idea. Cuts down the number of appointments and time spent in* clinic" (Mum)

"*Really good idea. Kills 3 birds with one stone and lots of support*" (Aunt)

80. Staff also really enjoyed being part of the process and developing the improvements together and I was delighted that Abbie Kyffin, Integrated Therapy Team Leader, Integrated Children's Therapies, shared a vlog with the organisation in our Beyond Boundaries series about this innovative project.

81. I wish both teams the very best of luck for the awards ceremony on 20 September 2021.

IPC Care Home Project

82. This project is facilitated in partnership with the Local Authority, providing dedicated support to 125 care homes across Wirral.

83. An IPC standards assurance framework was developed in SAFE with each care home assigned a dedicated link nurse to support with Infection Prevention and Control training, knowledge and skills across the workforce. Being able to build up a strong relationship and having a single point of contact has been welcomed by care home staff. Managers complete monthly and quarterly checklists showing compliance against best practice for these areas and with the click of a button they can gather evidence to demonstrate IPC compliance.

84. The care home managers have also reported increased confidence and assurance around IPC standards and regulations, in addition to having a central repository for storing and presenting evidence.

QNI - recognition of The Warrens District Nursing Team

85. We were delighted to receive a letter from the Queen's Nursing Institute (QNI) advising us that it was *"the chosen charity to receive a very generous donation as a direct result of the fabulous end of life care provided for a gentleman by the team".*

86. The gentleman's wife had taken time to write to the QNI to express her gratitude for the wonderful care received and I am not only very grateful for this recognition of our nursing teams but I also want to extend my sincere thanks to the nursing team at The Warrens for their exemplary practice and for the care and compassion they showed to their patient and his family.

Royal College of Occupational Therapy (RCOT)

87. Congratulations to Chris Smith and Sharon Davenport whose feature article on the "Introduction and use of the Therapy Outcome Measure (TOMs) in Adult Social Care" for the Royal College of Occupational Therapy (RCOT) professional magazine OT News was published in the July 2021 edition.

NHS Benchmarking Network

88. Congratulations to Caroline Golder and colleagues in the Community Cardiology Service who have recently been featured in an NHS Benchmarking Network publication highlighting how the service successful transformed its cardiology rehabilitation resources to a digital offer during COVID-19 and their plans for future on-line materials to support individual's recovery.

89. See attached publication and well done to all involved in achieving this national recognition and opportunity to showcase best practice.

National news and developments

Health and Care Bill

90. The government published the Health and Care Bill on 6 July 2021.

91. The Bill follows proposals for legislative change originally brought forward by NHS England and NHS Improvement (NHSE/I) in autumn 2019. These were further developed in the Integrating Care consultation with regard to system working and, most

recently, in the Department of Health and Social Care's (DHSC's) Integration and innovation white paper published in February this year.

92. The majority of the Bill is focused on developing system working, with integrated care systems (ICSs) being put on a statutory footing. It also 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.

93. Other measures proposed 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 workforce responsibilities.

94. NHS Providers have published a very interesting briefing which is attached to this paper for information.

George Cross (GC) Award

95. The recognition of the work of the NHS with the award of the George Cross to mark the NHS 73rd birthday was wonderful. The Queen's statement talked of 'courage, compassion and dedication' all of which has been unwavering throughout the pandemic and continues through our recovery.

96. I hope that every member of NHS staff, in every organisation and in every role is proud of this significant and historical award.

NHS System Oversight Framework 2021-22

97. The NHS System Oversight Framework was published in June 2021 and outlines NHS England and NHS Improvement's approach to oversight for 2021/22, one that reinforces system-led delivery of integrated care.

98. The framework reflects the vision set out in the NHS Long Term Plan, *Integrating care: Next steps to building strong and effective integrated care systems across England*, the White Paper *Integration and innovation: Working together to improve health and social care for all*, and aligns with the priorities set out in the 2021/22 Operational Planning Guidance.

99. In 2021/22, the NHS will continue to manage the impact of COVID-19 and provide the full range of non-COVID services within an evolving local, regional and national context.

100. The purpose of the NHS System Oversight Framework is to:

- align the priorities of ICSs and the NHS organisations within them
- identify where ICSs and NHS organisations may benefit from or require support to meet the standards required of them in a sustainable way, and deliver the overall objectives for the sector in line with the priorities set out in the 2021/22 Operational Planning Guidance, the NHS Long Term Plan and the NHS People Plan
- provide an objective basis for decisions about when and how NHS England and NHS Improvement will intervene in cases where there are serious problems or risks to the quality of care.

101. The approach to oversight is characterised by the following key principles:

- working with and through ICSs, wherever possible, to tackle problems
- a greater emphasis on system performance and quality of care outcomes, alongside the contributions of individual healthcare providers and commissioners to system goals
- matching accountability for results with improvement support, as appropriate
- greater autonomy for ICSs and NHS organisations with evidence of collective working and a track record of successful delivery of NHS priorities, including tackling inequality, health outcomes and access e. compassionate leadership behaviours that underpin all oversight interactions.

New Integrated Care System Design Framework

102. NHS England and NHS Improvement has published a new integrated care system (ICS) design framework, to support progression and development.

103. It sets out some of the ways NHS leaders and organisations will operate with their partners in ICSs from April 2022.

104. It is subject to legislation, which is expected to begin passage through Parliament before the end of summer.

105. The full document can be accessed on-line via the following link NHS England » Integrated Care Systems: Design framework

CQC changes for more flexible and responsive regulation - summary of responses to consultation

106. The CQC has published its summary of responses to its recent consultation and confirmed next steps.

107. The consultation ran from January 2021 and outlined proposed changes to how CQC intends to assess services more flexibly and responsively and make changes to the way it calculates and displays ratings.

108. Its specific proposals include;

- **To assess quality and rate services by using a wider range of regulatory approaches** including a range of sources of information and feedback, rather than relying solely on a schedule of set-piece inspections.
- **To move to a more flexible, risk-based approach determining how often it assesses and rates services, rather than following a fixed schedule of inspections.** It will also move to an approach to rating services that will allow it to update a service's rating without a site visit.
- **To remove aggregation for NHS trust-level ratings and develop its current approach to assessing the well-led key question for a trust.** Rather than provide trust-level ratings for each of the five key lines of enquiry (safe, effective, responsive, caring and well-led), it will only publish these at the service level and instead produce a separate trust-level rating based on an assessment of well-led.

109. A briefing from NHS Providers summarises the feedback CQC received during the consultation process and its response to queries and concerns raised by its stakeholders. Key points include;

- There was strong support for the broader proposals outlined above, including using a **wider range of regulatory approaches** and **simplifying the ratings process** to make them clearer and easier to understand.
- CQC addressed concerns from respondents about whether the ratings will provide enough detail about **variation between services within a trust**. CQC clarified that it will no longer aggregate service-level ratings together to give trust-level ratings for the safe, effective, caring and responsive key lines of enquiry.
- Respondents also highlighted the need for **trust-level assessments to continue to reflect quality at service level**. CQC confirmed that its new approach will be based on a "development" of the well-led key question. It intends to work with providers as it strengthens its well-led framework in areas such as collaboration, equality, diversity, and inclusion.
- CQC emphasised that its **ratings will be more dynamic** and responsive to evidence that demonstrates a change in quality and will not always require an inspection to be changed. It also offered assurance that it intends to use a combination of all its regulatory methods, including site visits where necessary.
- Respondents outlined concerns regarding the **quality and reliability of data drawn from wider sources** to assess quality of care. CQC clarified that it intends to work with stakeholders, including providers, to ensure they are using the best and most up-to-date data and information about services.

110. The NHS Providers briefing can be accessed via the following link - https://nhsproviders.org/media/691805/next-day-briefing_cqc-response-to-its-consultation-on-flexible-and-responsive-regulation_final.pdf

Communications and Engagement

111. Our monthly Executive Briefing was rebranded in July 2021 to support the launch of the new Trust common purpose statement and values.

112. The 'Get Together - Team WCHC' is an on-line event, open to every member of staff across the Trust. We were delighted that in July we had over 100 members of staff join us to listen to news and updates from across the Trust but also to participate in a live and interactive poll using Sli.do.

113. We are eager to use this engagement forum as an opportunity to understand feedback from the monthly NHS People Pulse survey and the response we have received thus far, has been not only encouraging but also very useful.

114. I look forward to future Get Together sessions; the dates for next 6 months have been published on Staff Zone and for any member of staff unable to attend a summary of the briefing and the Sli.do poll is produced and available on Staff Zone.

115. In June 2021 I attended the now monthly Joint Forum meetings with our staff side and trade union representatives. In the spirit of partnership working I am pleased that we are now working to a monthly schedule for these meetings.

116. During April and May 2021, I have continued to represent the Trust at regular system meetings including North West Leaders, Cheshire & Merseyside Providers Chief Executives, and Cheshire & Merseyside Providers Out of Hospital Chief Executives. The Healthy Wirral Partners Board has continued to meet bi-weekly and together with the Chair and Deputy Chief Executive/Chief Finance Officer we have attended and remain committed with our partners to developing plans for the local health and care system and the Wirral place.

North West system leaders

117. I have continued to attend fortnightly NW System Leaders meetings, led by NHSE/I Regional Directors providing an update on the NHS response to COVID-19 across the region, vaccination rates and the restoration of elective hospital activity. More recently these meetings have also focused on NHS priorities for the next 12 months and the regional financial position, including the allocation of capital funding.

Reciprocal mentoring

118. I have previously reported that as a Trust we were excited to be embarking upon a programme of reciprocal mentoring with colleagues from our BAME Staff Network, supported by Liverpool John Moores University. Since my last report, I have been delighted to meet with Yinka Koomson, chair of the BAME Staff Network and my mentor/mentee. We have already had such fruitful and engaging conversations and I was grateful to Yinka for supporting me in a joint vlog to the organisation about this exciting initiative.

Summary of Executive Leadership Team (ELT) business

119. Following the standing down of the Strategic Command Group as part of the Trust's local command structure, ELT has continued to receive a weekly update on the epidemiological position in Wirral from the Chief Nurse, and a monthly update from the Chief Operating Officer on ED attendances, hospital occupancy and discharges and emergency beds capacity

120. In addition, ELT has continued to receive regular updates on the following:

- The work of the ICP Delivery Group which had been established to oversee the reviews of the Health and Wellbeing Board and the Integrated Commissioning Group and agree the form/function, enabling functions and opportunities for integration of the Provider Collaborative in Wirral.
- Developments across the national, regional and Wirral health and care systems including the development of the Cheshire & Mersey ICS.

- Developments relating to the Community Integrated Care Centre including the development of two further wards managed by the Trust to support Discharge to Assess provision
- Action plans drawn up in relation to concerns raised in individual services.
- The collaborative work that the Trust is undertaking with Wirral Council and an external change management agency to transform social work practice and ensure a full strength-based approach.
- The Trust's operational redesign process, including implementation and the appointment of Service Directors
- All high-level organisational risks with a rating of 15 or above, which are reviewed by ELT until such time as the Oversight & Management Board (to be redesignated as Integrated Performance Board in the new governance structure) is re-established.

121. In accordance with the emergency governance arrangements established in March 2020, ELT has continued to receive capital business cases for approval until such time as the Programme Management Board (to be redesignated as Programme Management Group in the new governance structure) is re-established.

122. During June and July2021 the following proposals were presented to ELT for approval:

- Submission of a tender for the Wirral 0-19 Health Improvement Programme
- Proposed changes to the complaint's response process aimed at standardising the quality of responses and formalising the learning process.
- The Trust's Quality Account, for comment ahead of submission to the Board of Directors for formal approval.
- A proposal for the Trust to enter into the consultation process for Level 1 Kitemark Accreditation for Social Value.
- The proposed new governance structure following the reset from emergency governance arrangements.
- Amendments to the vacancy approval process for Band 8A and Band 8B and above posts
- Allocation of funding from reserves to provide lightweight summer uniforms for eligible clinical staff
- The principles of the Trust's Agile Working process and a proposal to run a pilot of a 'co-production' agile working approach during August 2021
- The rebranding of Executive Brief to 'Get Together - Team WCHC Briefing'.

123. Additional items were also presented to ELT for assurance or discussion including,

- A series of presentations on the CQC Regulatory Compliance Programme, following deep dives into each of the regulations, highlighting areas where further action was required to strengthen compliance
- An update on the NHS Cadets programme
- A briefing from a National COVID-19 Inquiry webinar
- A briefing on safeguarding activity during the pandemic
- An overview of the mechanism in place for monitoring the Trust's subcontracts with WUTH and other providers
- An update on the campaign to increase public membership in Cheshire East.
- Demonstration of a waiting list dashboard on the Trust Information Gateway (TIG) which is in the process of being developed

- An update on the operational plans in place to support a reduction in expenditure on agency use
- An overview of 2021/22 Clinical Continuing Professional Development (CPD) funding and processes by which clinical CPD was commissioned and provided.
- An update on the NHSE Ageing Well (Long-Term Plan) priorities and how they align with Healthy Wirral workstreams.
- An overview of the specifications for the Well-Led and Board CQC Preparedness programmes
- An overview of the Trust's Pulse Survey results in May and June 2021

Conclusion

124. I hope you find this report interesting and helpful and it provides a clear description of the current priorities for the Trust and the key activities underway to address them.

Karen Howell
Chief Executive

Alison Hughes
Director of Corporate Affairs

26 July 2021

The Health and Care Bill

The government has today published the Health and Care Bill. This briefing sets out an overview of proposals, a summary of the key parts of the Bill as well as NHS Providers' view on these provisions. We have focused on the areas of particular interest to members and where we will seek to influence the Bill as it progresses through parliament. If you have any comments on the proposals that you would like to help inform our work on the Bill, please contact Cath Witcombe, public affairs manager, and Finola Kelly, senior legislation manager.

Overview

- The publication of the Health and Care Bill follows a limited set of proposals for legislative change originally brought forward by NHS England and NHS Improvement (NHSE/I) in autumn 2019 before the COVID-19 pandemic. These were further developed in the *Integrating Care* consultation with regard to system working and, most recently, in the Department of Health and Social Care's (DHSC's) Integration and Innovation white paper published in February this year. It also incorporates proposals for the Health Service Safety Investigations Body which were part of previous legislation which did not make it on to the statute book during a previous session of parliament.
- The majority of the Bill is focused on developing system working, with integrated care systems (ICSs) being put on a statutory footing. It also 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 measures proposed 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 workforce responsibilities.
- The government has stated that the Health and Care Bill will allow it to build and shape a health system that is better able to serve the people of England in a fast-changing world. Its intention is to create a system that is more accountable and responsive to the people that work in it and the people that use it. We support this direction of travel and the opportunity the Bill presents to design the right system architecture that will deliver sustainable high-quality care for the future. We believe there are a number of improvements that can be made which will make this the transformative piece of legislation the government wants it to be.

- The Bill introduces a two-part statutory ICS model, with an ICS in future comprising an integrated care board (ICB), bringing together the organisations that plan and deliver NHS services within the geographic area covered by the ICS (the white paper called this part the ICS NHS Body) and an integrated care partnership (ICP), bringing together a broad alliance of organisations related to improving health and care (the white paper called this part the Health and Care Partnership).
- The Bill includes provisions which cumulatively amount to far-reaching powers for the secretary of state. This includes powers of direction over NHS England and the ability to intervene at any stage in local service reconfigurations. We are concerned to ensure the NHS' clinical and operational independence and avoid the risk of political interference in the provision of services and will therefore seek appropriate safeguards to balance these powers.
- The Bill gives NHS England the power to set capital spending limits for foundation trusts. We will be seeking to amend the current proposals by asking parliament to consider adding a number of safeguards which were previously agreed between NHS Providers and NHSE/I in 2019.
- We welcome a new duty on the secretary of state to set out how workforce planning responsibilities are to be discharged, but believe that an additional duty should be added to the Bill to ensure the development of regular, public, annually updated, long-term workforce projections. There should also be a duty to regularly update parliament on the government's strategy to deliver those long-term projections, including its approach to providing the required funding.
- The Bill also includes a number of changes to local financial arrangements. This includes setting requirements to meet financial objectives and balance, with NHS England having the ability to set additional and mandatory financial objectives specifically for NHS trusts. While we support greater integration within health services and across health and care, in the event that local organisations believe an impossible task has been set it is important that the legislation also establishes clear routes for recourse.
- We strongly support putting the Health Service Safety Investigations Body (HSSIB) on a statutory footing and setting out the framework for its conduct of safe space investigations so that the NHS can improve patient care and learn from when things go wrong. Nevertheless, we are keen to ensure that the Bill provisions genuinely enable the HSSIB's independence, which is crucial to its ability to carry out its intended systemic safety role, as well as protecting the integrity of safe space.
- As the country emerges from the pandemic, the NHS continues to face considerable challenges including in direct response to COVID-19; the backlog of care and restoration of elective care; persistent and severe pressures on the workforce; and the impact of prolonged under-investment. The impact of amending the legislative framework within which the NHS operates and the

additional burden this will create for the NHS and its staff should not be underestimated at this time.

- We will continue to work with the government, parliament and stakeholders as the Bill progresses, highlighting where we believe the legislation could be improved and amended. It will be vital for the government to continue listening to the views of those on the frontline to ensure the proposals best support the NHS and the patients and service users it cares for.

At 135 clauses and 16 schedules the Health and Care Bill is a long piece of legislation. It is divided into 6 parts covering the following areas:

Part 1 – Health service in England: integration, collaboration and other changes
Part 2 – Health and adult social care: information
Part 3 – Secretary of state's powers to transfer or delegate functions
Part 4 – The Health Services Safety Investigations Body
Parts 5 and 6 – Miscellaneous and general

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

NHS England (clauses 1-11; schedule 1)

Summary

These clauses made a number of provisions to NHS England and its ways of working. This includes:

- renaming the NHS Commissioning Board to NHS England
- giving the secretary of state the power to veto any proposal from NHS England on the commissioning of specialised services
- making it easier for the secretary of state to change the mandate in-year
- introducing a duty on NHS England to have regard to the likely effects of making any decision to exercise its functions on:
    - the health and well-being of the people of England
    - the quality of services provided, changes to prevention, diagnosis or treatment
    - efficiency and sustainability across the NHS.

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 integrated care boards (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 and payments. Enabling NHS England to give directions to one or more ICBs in respect of any of the ICB's functions and payments. Regulations may be made limiting this power. The ICB becomes liable for any tort arising from the direction.
- Extending the right to be included in public involvement and consultation to carers and representatives.

In addition:

- NHS England will be subject to a duty to prepare consolidated accounts for NHS trusts and foundation trusts and submit them to the secretary of state, the comptroller and auditor general and submit them to parliament along with any report of the comptroller and auditor general upon them.
- The secretary of state will have the power to direct NHS England to use payments made to it for the purpose of integration and to direct how such payments may be used. NHS England will also have the right to make payments to ICBs in respect of integration.
- The power of the secretary of state to make regulations in respect of payments for quality will be removed and such payments will in future be able to be designated by direction.
- The right of NHS England to accept secondments from designated bodies is extended.

Key clauses and NHS Providers' view

Clause 3: NHS England mandate

This clause 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 is it replaced by a new mandate. The statutory link between the mandate and the annual financial cycle will be removed and the Bill proposes that NHS England's annual limits on capital and revenue resource be given statutory force through the financial directions.

NHS Providers' view

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

Clause 4: NHS England: wider effect of decisions

This clause 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 services provided; changes to prevention, diagnosis or treatment; and efficiency and sustainability across the NHS. NHS England must produce guidance as to how it will exercise this duty.

NHS Providers' view

This clause requires NHS England to have regard to the 'triple aim' duty, which will also apply to ICBs, trusts, foundation trusts (see clauses 15, 43 and 56). This clause seeks to legislate 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 clause does offer a new legal basis for decisions and could be used to justify greater expenditure on some services rather than others. Our expectation is that such decisions would always be clinically-led and evidence-based, but this may nevertheless be concerning for patient groups with rare diseases or for services which have been subject to local variation in the past. This clause may also become of greater concern should the clinical and operational independence of the NHS become diminished as a result of the proposed strengthened powers of direction for the secretary of state. We would welcome members' views on the practical impact of this clause, including how it may impact commissioning decisions and services.

Clause 9: 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. 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.

NHS Providers' view

We understand that this is a technical amendment to decouple the BCF from the NHS England mandate, rather than to fundamentally change the focus of the BCF.

Integrated care boards and Integrated care boards: functions (clauses 12-19; schedules 2 and 3)

Summary

Integrated care systems (ICSs) currently operate as health and care organisations working together as coalitions of the willing to coordinate, integrate and plan services, with a view to improving population health and tackling health inequalities. The Bill introduces a two-part statutory ICS model, with an ICS in future comprising:

- an integrated care board (ICB), bringing together the organisations that plan and deliver NHS services within the geographic area covered by the ICS (the white paper called this part the ICS NHS Body)
- an integrated care partnership (ICP), bringing together a broad alliance of organisations related to improving health and care (the white paper called this part the Health and Care Partnership).

This chapter of clauses and its schedules amend the National Health Service Act 2006 to describe the composition, constitution and functions of ICBs. The ICB will take on the commissioning functions and duties of clinical commissioning groups (CCGs), which will be abolished on the same day that ICBs are established as corporate bodies (clause 13). The CCG(s) within the system footprint must consult with relevant parties and propose the first ICB constitution, taking into account any guidance published by NHS England.

An ICB will have several duties (clauses 15 and 19), 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, and having regard to the 'triple aim' of better health for everyone, better care for all and efficient use of NHS resources. Further, ICBs must ensure patients and communities are involved in the planning and commissioning of services; NHS England must publish guidance for ICBs on the discharge of their functions; and ICBs must have regard to this guidance.

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 nominated by NHS trusts and foundation trusts, one by general practice and one by local authorities (LAs) 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). 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.

Clause 19 (along with schedule 2) further sets out that the ICB and its 'partner' trusts and foundation trusts must prepare a five-year plan (with regard to and in consultation with relevant Health and Wellbeing Boards [HWBs] and their strategies) setting out how they propose to exercise their functions. They must also create a joint capital plan for a period specified by secretary of state. The ICB must prepare accounts and create an annual report. 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 Bill 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).

NHS Providers' view

The national role in developing system working

We support the government's ambition to embed the success of collaboration and system working, as especially seen during the COVID-19 response. However, some trust leaders are increasingly concerned about a mismatch between the pace and scale of change, and the sector's capacity to carry out this major transformation at the same time as they are grappling with pandemic recovery. We urge flexibility around the timing of implementation, such as allowing for ICBs to take on functions when they judge themselves ready, enabling ICBs to exercise functions jointly with NHS England, and clarifying whether there will be a shadow implementation period.

We are keen to see an enabling, flexible legislative framework that accelerates the current direction of system working. While the narrative in the white paper aligned with this approach, we are concerned that the provisions in the Bill and accompanying guidance from NHSE/I and DHSC to date risk undermining this intention. For example, the level of detail around the ICB's membership, appointments and composition, alongside provision for an increased level of control and direction over ICBs from NHS England and secretary of state, indicates a shift further towards a tightly managed, centrally controlled NHS system architecture. Elsewhere in the Bill, for example, NHS England's and the secretary of state's duties to promote autonomy are removed (clause 62). This is framed in the context of greater collaboration, but we note with some concern that the explanatory notes position this removal as making way for the secretary of state's powers of direction over NHS

England. We are worried that this tendency to centralise and direct will be passed down to ICBs in their leadership and culture. This conflicts with the principle that locally designed systems will best improve patient care and is liable to forcing attention upwards, rather than promoting subsidiarity.

We are concerned that collective confidence in an ICB could be undermined by an excessively top-down approach, which could hinder the opportunity and ambition of system working:

- Schedule 2 states that an ICB chair will be appointed by NHS England with approval from the secretary of state and no involvement of the ICB members or wider system partners. This is concerning as the chair needs to have the confidence of the ICB and system partners. We urge the government to ensure a significant role for these bodies in the recruitment of the chair, even if powers of appointment lie elsewhere.
- The Bill provides for NHS England alone, with approval of the secretary of state, to remove the chair from office. However, it seems probable in the medium term, as local arrangements develop and get underway, that an ICB chair maylose the confidence of the ICB and/or the organisations within the system. Where this happens there must be a role for the ICB board in initiating the removal of the chair and this needs to be addressed in the constitution. If the ICB cannot initiate the removal of the chair, this will potentially lead to conflict, a stalemate and potential disruption to services.
- Schedule 2 makes the appointment of ordinary members subject to the chair's approval. We believe the whole board should approve the appointment of ordinary members (not the chair alone), to maintain the principle of collective responsibility that is central to good governance.

The role of the ICB and its relationship with local health and care bodies

There must be clarity on how the accountabilities of all parts of a local health and care system align without duplication, overlap or additional bureaucracy. For example, some of an ICB's duties as currently set out – such as the duty of quality improvement – risk overlapping with those of trusts. While we agree the board of an ICB will need to be formally accountable to parliament via DHSC and NHS England, the ICB should also see themselves as accountable to the communities they serve and the organisations within their footprint. There should be an obligation on NHS England in the Bill to set this out explicitly in future guidance. In addition, we see that the explanatory notes to the bill state that the ICB will be directly accountable for NHS spend and performance within the system. This does not appear to be explicit within the Bill, however, and we will seek clarity from the government as to the intentions here.

We are pleased to see the reference to ICBs and trusts and foundation trusts jointly developing the system's plan to meet the health needs of their population and jointly setting out how they will

exercise their functions to achieve that plan. We were clear in our discussions with DHSC and NHSE/I that this needed to be a joint endeavour, and we urge the government to extend the principle of co-production to the development of an ICB's composition and constitution. The consultation process for establishing an ICB and drafting an ICB constitution is currently framed as a CCG-led process, and therefore risks lacking appropriate consultation with trusts and wider system partners which would make it more robust. There needs to be a requirement in primary legislation for CCGs, trusts and wider partners to agree the composition and constitution of the ICB, as well as a statutory duty for the ICB to involve system partners in planning and commissioning decisions. There must be a requirement on NHS England to issue statutory guidance which ensures:

- each ICB has a mechanism which enables the views of all trusts to be heard as part of the ICB decision-making process
- each ICB has a robust process for agreeing the ordinary members
- each ICB has a challenge mechanism for trusts, in extremis, to raise concerns to NHS England about the ICB composition, constitution and plans.

We support the government's stated aim in the white paper to reduce the bureaucratic burden on the health and care system, but are concerned about the ever-increasing demands that system working places on trust leaders' time and moreover, that this will happen without any commensurate increase in resources. Taken together with the recent ICS design framework and system oversight framework, the statutory ICB risks creating an additional management and oversight tier rather than taking bureaucratic burden away. We are particularly concerned about how the relationship between trusts and ICBs is framed in the Bill. The clauses describe an ICB as a separate entity to its 'partners', rather than as a genuine partnership of all the organisations that contribute to health and care services and outcomes within the system. This model risks moving away from the founding spirit of partnership and the design principle of the ICS as a sum of its parts, and towards becoming a separate body managing those within it.

Finally, CCGs have largely been repurposed into ICBs. We are concerned that this 'lift and shift' approach to repurposing leaves them open to the charge that the government is simply recreating CCGs on a larger footprint, rather than developing them into a broader strategic, population health planning function. It is clear that the purchaser/provider split is not being fully removed in the Bill, so the link between providers and commissioners in an ICB needs to be sufficiently improved and strengthened by having robust provider input into ICB decision-making.

ICPs and Integrated care system: further amendments (clauses 20 and 25: schedule 4)

Summary

The Bill states that an ICB and relevant LAs must establish a statutory joint committee for the system – an ICP – which will bring together health, social care, public health and wider partners. The ICP membership will include one member appointed by the ICB, one member appointed by each of the relevant LAs, and any other members appointed by the ICP. The ICP will be able to determine its own procedures locally.

The ICP must prepare an 'integrated care strategy', building on the relevant joint strategic needs assessments (JSNAs) and considering the effectiveness of establishing section 75 arrangements. The ICP must have regard to guidance issued by the secretary of state. 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 LAs. There is a requirement for LAs and the ICB, in response and with regard to the integrated care strategy, to create a joint local health and wellbeing strategy.

NHS Providers' view

We support the lack of prescription around the membership of the ICP on the face of the Bill and the principle of the ICP being a partnership of equals. However, if all relevant LAs, who are already represented in the ICB by a 'partner' member, are each involved in setting up the ICP and represented by individual members, without additional provider representation, there will be an inappropriate imbalance when establishing the ICP which undermines the principle of equal partnership.

We support the creation of ICPs as joint committees rather than statutory organisations, and understand the rationale behind a separate body that brings the NHS in England, local government and wider partners together to focus on tackling health inequalities and the wider determinants of health. However, we note that this means an ICP's functions and duties, and the liabilities that accrue from them, will fall to individual members of an ICP. This may become problematic if an ICP's functions and duties conflict with the duties and liabilities of these individuals as directors, and there needs to be clarity as to where directors' duties lie. There also needs to be clarity as the accountability of an ICP and its members in agreeing that strategy.

Integrated care system: financial controls (clauses 21-24)

Summary

These clauses 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 by direction from 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.

NHS Providers' view

Providers understand how the allocation and distribution of funding at ICB level can make a positive contribution towards the 'triple aim' of better health and wellbeing for everyone, better quality of health services for all individuals, and sustainable use of NHS resources. The 'system first approach' to financial management driven by the response to COVID-19 appears to have been a largely positive experience.

However, it is important to reflect on what has worked well to date, and embed this in legislation (and guidance) to maximise the chances of the new financial regime being a success. As things stand, we are concerned that the Bill does not strike the right balance between embracing the opportunities presented by more collaborative working, and protecting ICBs, trusts and foundation trusts – and ultimately patients – when things do not go as planned. For example, in the event that an ICB, trust or foundation trust feels it has been given an impossible task – say if it is concerned that 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 exist.

It does not call into question the commitment of any of an ICB's partners to recognise that legislation needs to make provision for those difficult situations which, at times, will be unavoidable as much as partners may regret this. As such, we would welcome the opportunity to work with DHSC and NHS England to explore what a reasonable system of checks and balances might look like. We want to ensure that if and when tensions arise, they can be resolved quickly, fairly and transparently.

Furthermore, we urge the government to give careful consideration to the conditions needed to enable ICBs, and their partner trusts and foundation trusts, to collectively deliver financial balance. This will require an open and honest conversation ahead of the Comprehensive Spending Review

about the funding needed to fully recover from COVID-19, transform the NHS, and build greater resilience into the wider health and care system.

Merger of NHS bodies (clauses 26-32; schedule 5)

Summary

Clause 26 abolishes Monitor, with schedule 5 making consequential amendments relating to the transfer of Monitor's functions to NHS England. This fulfils the intention of DHSC to merge Monitor into NHS England to form a single body. Clause 27 places a duty on NHS England to minimise the risk of conflict between its regulatory and other functions, and managing any conflicts that arise. Clause 28 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. Clause 29 transfers powers from the Trust Development Authority (TDA) to NHS England and abolishes the TDA.

NHS Providers' view

Overall, we support the move to merge Monitor and the TDA into NHS England and welcome the consistency and clarity it will offer. However, we note this raises a series of questions for the new NHS England as a single organisation that concurrently sets the national policy framework, supports improvement, and acts as a regulator. The merger removes the inherent tension deliberately created by the Health and Social Care Act 2012 which replicated a commissioner/provider split at a national level, and consolidates the direction of travel with NHS England seeking to operate as a more integrated body. However, while the Bill contains some useful provision for NHS England to manage conflicts of interest, this does not negate the fact that NHS England will be required to oversee and regulate the outcome of its own decisions. We will continue to work with DHSC and NHS England to understand the implications of this change in practice and what further safeguards may be needed to account for potential conflicts of interest between NHS England's various functions and powers.

Secretary of state's functions (clauses 33-38; schedule 6)

Summary

These clauses 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. A duty on the secretary of state regarding publication of an assessment of the workforce needs of the health service in England is also set out.

Key clauses and NHS Providers' view

Clause 33: Report on assessing and meeting workforce needs

This clause 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

The intent of this clause is to add clarity and transparency on roles and responsibilities within the NHS on workforce planning. This is a welcome step forward and acknowledgement of the multiple bodies involved in this work. However, this duty will also essentially act to set out the status quo. The NHS desperately needs a long-term workforce numbers plan setting out the desired future shape and size of the workforce. We have called for an additional duty in the Bill to ensure the development of regular, public, long-term workforce projections drawing on input from all relevant NHS arm's length bodies, NHS frontline organisations such as ICBs and trusts, and expert bodies such as think tanks. These projections should set out, independently from ministers, on an arm's length basis, the size and shape of the future workforce needed to deliver safe, effective, high-quality care and the estimated cost of delivering this workforce. There should then be a duty on the secretary of state to regularly update parliament, more than once a parliament, on the government's strategy to deliver those long-term projections, including its approach to providing the required funding.

Clause 34: Arrangements for exercise of public health functions: arrangements; and clause 35: Power of direction: public health functions

Clause 34 allows for any of the secretary of state's public health functions to be exercised by NHS England, an ICB, a LA that has duties to improve public health, a combined authority, or any other body that is specified in regulations. Clause 35 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.

NHS Providers' view

Existing legislation enables the secretary of state to delegate public health functions by agreement. As part of this, NHS England currently commissions a range of services, including national immunisation and screening programmes. However, the secretary of state cannot require NHS England or any other NHS body to take on a delegated public health function, which may mean that the secretary of

state will be unable to deliver an aspect of their duties. The proposed clause in the Bill provides the secretary of state with greater flexibility as to which body carries out public health functions.

We support the introduction of flexibility for the secretary of state to direct NHS England to carry out delegated public health functions. We have previously highlighted the challenges associated with the LA commissioning of certain clinical public health services including health visiting, sexual health services and drug and alcohol services. Fragmentation and underfunding of services have undermined the ability of trusts, who are frequently commissioned to provide these services, to effectively deliver services and meet the needs of local communities. These services would be better placed to sit within the NHS and be commissioned alongside other clinical services, and so we welcome the opportunity for NHS England to play a greater role in commissioning services.

While we support this proposal, changes to the delegation of public health functions must not be considered as a cure-all for challenges faced by public health. Underfunding of services will continue to present challenges, regardless of who is delivering services. Should any future proposal be brought forward under this power, we would emphasise the need for it to be subject to full and wide consultation with a range of partners both within and outside the NHS.

Clause 36: Power of direction: investigation functions

Clause 36 enables the secretary of state to direct NHS England (if they consider it 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 by the Healthcare Safety Investigation Branch (HSIB) under ministerial directions relating to its investigative functions and its additional investigative functions in respect of maternity cases.

NHS Providers' view

Further clarity on this clause and how it works alongside Part 4 of the Bill and the work that the HSSIB would undertake would be welcome. In particular, it would be helpful to understand the intended approach to the maternity investigations currently undertaken by the HSIB. The HSIB has had a valuable role in identifying how NHS providers can sustainably and systematically improve the quality of their maternity investigations and then appropriately support those providers to make the required improvements. However, it remains important for these investigations to return to the NHS at an appropriate point to ensure proper accountability, to support a trust's relationships with the affected families and staff, and to avoid the loss of skill within the NHS in carrying out such investigations. We also note that the explanatory notes state, 'the Bill will establish a new statutory body which will largely replace the Investigation Branch', and we will seek clarification as to the intent there.

Clause 37: General power to direct NHS England

Clause 37 give the secretary of state the power to direct NHS England in relation to their 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.

NHS Providers' view

This is a key provision to note as it appears to signal a recentralisation of power and to open up the possibility of ministers' involvement in aspects of the operational management of the health service. We are concerned that without appropriate safeguards in place, decisions might be reached based on political motivation rather than focused on the best interests of services and populations. The clinical and operational independence of the NHS must be maintained to ensure equity for patients within the service, best use of constrained funding, and clinical leadership with regard to prioritisation and patient care. We are concerned that there are no protections to mitigate against the involvement of the secretary of state in the day-to-day running of the NHS. This could arguably expose the government, any secretary of state, the service and patient care to undue, unmanaged risk.

The clause indicates that a direction must include a statement that the secretary of state considers the direction to be in the public interest and that this should be published as soon as is reasonably practicable. We are concerned that the way in which the 'public interest test' has been drafted is a subjective test, applied by the secretary of state. This could leave the secretary of state able to intervene in individual funding allocations. We believe there needs to be further discussion about whether such broad powers are necessary and proportionate, and would also encourage setting out specific criteria that must be met and a 'public interest test' for the deployment of these powers.

Clause 38: Reconfiguration of services: intervention powers; and schedule 6

Clause 38 gives the secretary of state intervention powers in relation to the reconfiguration of NHS services. Arrangements are detailed in schedule 7, 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. It also places a duty on an NHS commissioning body, NHS trust or foundation trust to notify the secretary of state when a reconfiguration is considered likely to be needed. The schedule gives the secretary of state power to give a direction calling in any proposal for the reconfiguration of services. The secretary of state can then take on the decision-making role of the NHS commissioning body concerned (for example, whether a proposal should proceed or not or whether the proposal should be modified). It also allows for the secretary of state to retake any

decision previously taken by the NHS commissioning body. When the secretary of state has made a decision, they must publish any decision made about a reconfiguration and notify the NHS commissioning body concerned of the decision.

NHS Providers' view

This gives wide ranging powers to the secretary of state to direct local service reconfigurations, and does so without appropriate safeguards. Decisions on local service reconfigurations are best taken locally by the organisations that are accountable for those services following meaningful engagement with local communities. While clarity and speed can be welcome in making such decisions, this should not be at the expense of local engagement and decision-making. The proposed powers risk undermining local accountability in the NHS, and local authority overview and scrutiny committees. They do not necessarily protect the best interests of patients and run the risk of political interference in the provision of local NHS services. In order to ensure that this power does not adversely affect services and patient care we believe that the following principles should be applied and set out on the face the Bill:

1. Any secretary of state involvement should be fully transparent, with the right of the affected parties to make appropriate representation and the secretary of state's intervention made against set, public, criteria
2. There is an appropriate role for an independent body like the Independent Reconfiguration Panel to provide independent advice on detailed issues including the validity and importance of the clinical case for change
3. There should be an appropriate threshold governing the level of reconfiguration where the secretary of state is involved
4. There should be an explicit test that use of the power must maintain or improve safety before it can be exercised.

NHS trusts (clauses 39-50; schedule 7)

Summary

A number of clauses in this chapter repeal redundant legislative sections, including some legislation which were never commenced – one example is provision in the Health and Social 2012 Act for the formal abolition of NHS trusts which was never commenced because the foundation trust pipeline was not completed as initially envisaged. This set of clauses also removes the power of the secretary of state to appoint trustees for an NHS trust to hold property on trust.

Clause 42 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.

Clause 43 sets out a new duty, which applies to ICBs, NHS England and foundation trusts and trusts in England (the 'relevant bodies'). This duty has been described by DHSC operationally as the 'triple aim' duty. ICBs and trusts will be under a duty when carrying out their functions, to have regard to all likely effects of their decisions on:

- the health and wellbeing of the people of England
- the quality of services provided or arranged by relevant bodies
- the efficiency and sustainability of resources used by 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.

Clauses 44 to 47 and clause 49 effectively give NHS England existing powers previously held by the TDA (and/or the secretary of state) over NHS trusts. Clause 49 gives NHS England the power to appoint the chair of an NHS trust, replacing the secretary of state's power here.

Clause 48 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 clause 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.

Clause 50 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 Providers' view

For the most part, our understanding of this group of clauses is that it 'tidies up' existing legislation in line with the proposed direction of travel under a single, statutory NHS England - dealing in particular with the consequences of the merger of TDA with NHS England. It reinforces some degree of equalisation between trusts and foundation trusts in terms of the application of the provider licence.

We are interested to see that the legislation leaves open the potential for NHS trusts to seek and secure foundation trust status. While we understand this is more of a convenience within the Bill than a policy expectation, we will of course explore this further with DHSC and NHSE/I colleagues.

Trust leaders will be interested to review the proposed clauses on the new 'triple aim' duty which will apply to ICBs, trusts and the new NHS England. Our views are set out above (see clause 4), and we would welcome feedback on the anticipated practical impact of this clause on your trust and ICB. While the amendments to clause 50 are relatively minor, the clause needs to be viewed within the context of the wider changes to financial arrangements outlined in the bill (specifically clauses 21-24 on ICS financial controls, and clause 66 and schedule 10 on the NHS payment scheme). At this stage, it is unclear how the clause will be implemented in practice – for example, the consequences that will be associated with a trust's failure to achieve its financial objectives. This is something we are urgently seeking clarity on.

NHS foundation trusts (clauses 51-57)

Summary

Clause 52 gives NHS England the power to set a capital expenditure limit on a foundation trust. Therein, NHS England has the power to establish an order to set a capital expenditure limit on a foundation trust for a defined period for which the order relates. It places a duty on NHS England to consult with the foundation trust before the order is made and requires NHS England to publish the order. The clause further imposes a statutory duty on the foundation trust not to exceed the capital expenditure limit, and sets the definition for capital expenditure in line with how capital is reported in the foundation trusts annual accounts. 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 will set 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.

Clause 54 will allow an NHS foundation trust to carry out its functions jointly with another organisation. The Bill will create a new legal mechanism that will allow ICBs and NHS providers to form joint committees, or two or more providers, to make joint arrangements and pool funds. Guidance will also be issued on joint appointments. Parallel measures in the Bill will also make it easier for ICBs 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.

The other clauses here amend existing legislation in line with the creation of a single merged NHS England and seek to streamline licensing and parts of the transactions process. In summary:

- Clause 51 means NHS England can treat existing foundation trusts and new foundation trusts created via merger as having applied and been granted a licence
- Clause 53 means that foundation trusts will send their forward plans to NHS England rather than Monitor. Other amendments allow for greater flexibility on how accounts are to be prepared.
- Clauses 55 removes the requirement that an application to merge a foundation trust with an NHS trust must be supported by the secretary of state. This clause would also place 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 and the secretary of state approves the grant of the application. An application to acquire a foundation trust or a trust similarly no longer requires the support of the secretary of state. This clause introduces a new duty on NHS England to grant the application if it is satisfied that necessary steps have been taken to prepare for acquisition and the secretary of state approves the grant of the application.
- Clause 56 removes the requirement for the grant of an application made by a foundation trust for dissolution to be based on the trust having no liabilities as currently set out in the National Health Service Act 2006. 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, a 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.
- Clause 57 reflects and reiterates the new 'triple aim duty'.

NHS Providers' view

We have significant concerns regarding the clause on capital spending limits for foundation trusts. The clause in the Bill does not mirror NHS England and NHS Improvement's September 2019

legislative proposal which was the result of detailed negotiations with NHS Providers on behalf of our foundation trust members. The clause also cuts across the Health and Social Care Committee's unequivocal position that the power to set capital spending limits for foundation trusts 'should be used only as a last resort'. We will ask parliament to consider adding the following safeguards to the Bill, which were agreed between NHS Providers and NHS England and NHS Improvement in 2019:

1. The power to set capital spending limits for foundation trusts should be circumscribed on the face of the Bill as a narrow reserve power;
2. Each use of the power should apply to a single named foundation trust individually;
3. Each foundation trust's capital spending limit should automatically cease at the end of the current financial year;
4. NHS England should be required to explain why use of the power was necessary, describe what steps it has taken to avoid requiring its use and include the response of the foundation trust when publishing each order; and
5. There should be a requirement for each order to be published in parliament, to ensure maximum transparency.

NHS trusts and NHS foundation trusts: transfer schemes between trusts (clause 58)

Summary

This allows for 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 an NHS foundation trust. The clause 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.

NHS trusts and NHS foundation trusts: Trust special administrators: (clause 59; schedule 8)

Summary

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 (clauses 60-61; schedule 9)

Summary

This enables NHS England, ICBs, trusts and foundation trusts to exercise their functions jointly with each other and/or local authorities. It also enables trusts and foundation trusts to establish joint committees and pooled funds with other trusts, foundation trusts, NHS England and ICB(s), and/or LAs. NHS England may publish guidance for NHS bodies in relation to joint working and delegation arrangements.

Collaborative working (clauses 62-65)

Summary

Clause 62 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 clause 36 (directions to NHS England) which gives the secretary of state the ability to direct NHS England in regard to the exercise of its functions.

Clause 63 gives NHS England the ability to issue guidance concerning joint appointments between one or more NHS commissioner and one or more NHS providers; between one or more NHS body and one or more LA, or one or more 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.

Clause 64 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 also imposes a duty on NHS bodies, except for Welsh NHS bodies, to have regard to this guidance. This clause also creates new powers which will impose a duty on NHS bodies and LAs (including Welsh NHS bodies and Welsh LAs) to co-operate with one another in order to advance the health and welfare of the people of England and Wales. It also inserts a new power for the secretary of state to make guidance related to England, and imposes a duty on NHS bodies and local authorities, except for Welsh NHS bodies and Welsh local authorities, to have regard to this guidance.

Clause 65 amends the 2012 Act to specify the purposes for which Monitor (which this Bill proposes to merge with NHS England) may set or modify the conditions contained in the licences which any provider of health care services for the purposes of the NHS must hold. In light of the creation of the 'triple aim' duty for NHS England, ICBs, foundation trusts and trusts, a new purpose for which licence conditions may be set or modified is being created, namely that of ensuring that decisions are

made with regard to all of their likely wider effects on the three factors which are included in the new 'duty to have regard to the effect of decisions'.

NHS Providers' view

NHS Providers supported NHS England's initial proposal in 2019 for a new 'duty to collaborate' in support of the aims of system working. We will seek views from DHSC colleagues as to whether the current wording of a 'duty to co-operate' materially alters the intent of these clauses in any way.

We note that clause 62 explicitly removes duties on the secretary of state and on NHS England to 'promote autonomy'. This reflects proposals elsewhere in the Bill to alter the relationship between the secretary of state and NHS England. Our position on the need to place much greater safeguards around many of the proposals on new powers of direction for the secretary of state are made elsewhere in this briefing. However, it is also worth noting that clause 62 similarly removes NHS England's duty to promote autonomy. Although this is in line with the direction of travel for trusts and their partners as they embed more collaborative arrangements within local systems (and sits in contrast to the 2012 Act which actively promoted competition) we will continue to argue strongly for the need for clear lines of accountability within the system, including clear lines of accountability from trust boards for the quality of care they deliver, and as large employers. In our view organisational autonomy can exist alongside collaboration and co-operation.

NHS payment scheme (clause 66; schedule 10)

Summary

Clause 66 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 clauses and NHS Providers' view

Schedule 10, paragraph 114D

Paragraph 114D deals with objections to the NHS payment scheme. The key difference to the existing statutory objection process for the national tariff is that 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.

NHS Providers' view

The introduction of the NHS payment scheme represents a move away from mandatory national prices for many services to commissioners having a greater say over the prices they pay providers. Trusts generally support this direction of travel and welcome the opportunity to have more open conversations about the true cost of providing services. We are working with NHSE/I to ensure that trusts' views are properly considered in the design of the NHS payment scheme (and that the benefits associated with the national tariff are not lost).

At the same time, we are concerned that the changes proposed appear to represent a cumulative loss of independent oversight, particularly with the removal of the CMA as a route to recourse. This could potentially increase the risk of an unworkable NHS payment system being imposed on ICBs and their constituent organisations. We would welcome the opportunity to work with DHSC and NHSE/I to ensure that the right checks and balances are enshrined in law.

Patient choice and provider selection (clauses 67-69; schedule 11)

Summary

These clauses 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. 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.

NHS Providers' view

We support the intention behind NHSE/I's proposals for a new NHS provider selection regime as we agree that the current rules for procuring healthcare services can unnecessarily disrupt the provision of high-quality local services and impede effective planning over the longer term. We understand why the legislative changes put forward in the Bill are necessary. However, more broadly, we have questions and concerns about how the regime will operate transparently and robustly in practice, and

believe that the inclusion of an appropriately defined challenge function would be beneficial. More detail can be found in our April 2021 response to NHSE/I's consultation. We are continuing to engage with NHSE/I as the regime develops and will keep members updated on our work in this area.

Competition (clauses 70-73; schedule 12)

Summary

Clause 70 proposes to require NHS England 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, and oversight and support and recommendations about restructuring.

Clause 71 introduces an exemption from Part 3 of the Enterprise Act 2002, removing CMA powers over trust mergers. Instead, NHS England, as the national body responsible for the NHS, will review mergers of NHS providers to ensure they are in the best interests of patients and the taxpayer.

Clause 72 also removes Monitor's competition duties ahead of the merger with NHS England to allow NHS England to focus more on improvement in the quality of care and use of NHS resources, and on the development of integrated care.

Clause 73 will remove 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, in consultation with local leaders.

Miscellaneous (clauses 74-78)

Summary

Clause 75 sets out requirements for Special Health Authorities (SpHAs) in relation to their accounts and auditing. Clause 76 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.

Clause 77 abolishes Local Education and Training Boards (LETBs).

Clause 78 revokes section 74 of the Care Act 2014 and schedule 3 of the Care Act 2014. Schedule 3 in the 2014 Act deals with the planning of discharge of patients in England from NHS hospital care to LA care and support. In revoking schedule 3 here, the procedural requirements which require social care needs assessments to be carried out by the relevant LA before a patient is discharged from hospital are repealed. It also repeals provisions which enable the responsible NHS body to charge the relevant LA via a penalty notice, where a patient's discharge from hospital has been delayed due to a failure of the LA to arrange for a social care needs assessment, after having received an assessment and discharge notice for an individual from the relevant NHS body.

NHS Providers' view

The abolition of LETBs to an extent formalises existing practice given that they have been progressively reduced in number and in importance in recent years. LETBs have ceased to be used as the primary vehicle for collaborative conversations within areas and regions on local education and training needs, and workforce planning more generally. Their function has been partly replaced by the recent establishment of regional people boards, set up by HEE and NHSE/I. Most regional people boards are chaired by or have a significant representation of trust leaders, which should help to ensure the flow of local intelligence on workforce needs and planning into discussions. However, it remains to be seen how local and ICB and system level discussions around workforce planning are managed within and outside these forums. We also note the need for any local changes to be supported by a fully funded long-term workforce plan.

It is important that arrangements to replace the function of LETBs – including through the establishment of regional people boards – do not repeat the mistakes made by the Care Act's excessive centralisation of local workforce planning functions. The original rationale for establishing LETBs had been to "build a system that is responsive to the needs of employers, the public and the service at local level". It is important this remains the aim, with an emphasis placed on the ability of trusts and other local actors to provide the intelligence required for effective workforce planning and commissioning of education and training. Providers are best placed to identify current and future resource gaps, and their continuing and growing input here is vital to establishing a rigorous and realistic evidence base.

Part 2: Health and adult social care: information

Clauses 79-85

Summary

The data provisions in the Bill are intended to work collectively to enable increased sharing and more effective use of data across the health and adult social care system. The general duties of the Health and Social Care Information Centre (the Information Centre; known as NHS Digital) will be amended so that it may only share information for purposes connected with the provision of health care or adult social care or the promotion of health. The Information Centre will be able to require private providers of health services to provide any information it requires in order to comply with a direction from the secretary of state. Other provisions enable the secretary of state to require certain providers of adult social care services to provide 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 LA in England, or outside England. There are also powers to enforce information provisions against private providers, as well as provisions that confer a delegated power on the appropriate authority to make regulations providing for a system of information in relation to medicines to be established and operated by the Information Centre, and specifying the type of provision which can be included in the regulations.

NHS Providers' view

We welcome the ambitions behind the proposals to facilitate greater sharing of information across health and care providers. Any policy or legislative proposals that clarify data sharing parameters for people will undoubtedly improve the pace of change. Improving data quality, access and flows will underpin three core NHS long term plan aims: moving to population health management, progressing the prevention agenda, and tackling health inequalities. There will also be gains in terms of patient safety and improved efficiency.

We recognise that the response to the COVID-19 pandemic has accelerated digital ways of working but with this increased use of digital technologies comes a renewed focus on interoperability. Interoperable systems improve the delivery of health and care, ensuring that clinicians have access to the right information at the right time. Greater interoperability will also underpin the integrated care agenda and help deliver shared care records across integrated care systems.

However, we are concerned that these legislative proposals do not address the underlying issues of bureaucratic burden around data collections in the health and care system. Data requests and record

management are constantly cited as the primary bureaucratic burden on staff of all types. Data requests from regulators, commissioners and the national bodies should be proportionate and have a direct link to improving care. The proposals seem to increase the reporting burden on providers rather than decrease them as per the white paper intentions, and it will be important to ensure that reporting is not used as a command and control tool.

Many trusts as well as other health and care providers need investment to improve their technical infrastructure, as data is only as good as the technical flows an organisation's infrastructure is capable of. Consideration therefore needs to be given as to the support and investment required here and the implications for implementation. Moreover, we are concerned to ensure an aligned approach to the digital agenda.

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

Clauses 86-92

Summary

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

NHS Providers' view

Of particular note here is clause 87, which would allow the secretary of state to transfer functions between bodies. The secretary of state may not change functions in a way so as to make NHS England redundant but they can abolish the other bodies by regulation. The power to abolish a body such as the HFEA, or the power to transfer the majority of their powers to other bodies, requires proper parliamentary scrutiny. We believe that such changes should require primary legislation.

Part 4: The Health Services Safety Investigations Body

Clauses 93-119; schedules 13, 14 and 15

Summary

Part 4 of the Bill puts the Health Services Safety Investigations Body (HSSIB) on a statutory footing. The organisation is currently 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

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

Key clauses and NHS Providers' view

Clause 95: Deciding which incidents to investigate

Under Clause 95, 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.

NHS Providers' view

The parliamentary joint committee on the Draft Health Service Safety Investigations Bill in 2018 made clear the importance of the HSSIB's independence of judgement in deciding what investigations it undertakes. We note that a direction "may provide for a person to exercise discretion in dealing with any matter", but this does not seem to be a sufficiently strong safeguard. If the secretary of state is to

be able to direct the HSSIB to carry out an investigation, then three explicit balancing provisions are needed to maintain the HSSIB's independence. Firstly, it must be able to decline to carry out the investigation where there is reasonable justification. Secondly, adequate funding must be made available to the HSSIB to enable it to carry out such investigations in order to avoid compromising its ability to carry out its investigative function as the HSSIB would otherwise determine. Thirdly, the continuing independence of the HSSIB in how it carries out any such investigation and the independence of its consequent recommendations is paramount and should be explicitly protected.

Clause 106: Prohibition on disclosure of HSSIB material; clause 107: Exceptions to prohibition on disclosure; and schedule 14

Clause 106 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.

Clause 107 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 four of the Bill, 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 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 to a person if the chief investigator reasonably believes it necessary:

- for the purposes of the carrying out of the HSSIB's investigation function
- for the purposes of the prosecution or investigation of an offence relating to investigations or to unlawful disclosure
- 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; and 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. Similar provisions apply for senior coroners to make applications for disclosure and onward disclosure.

NHS Providers' view

There is a wide body of research that evidences the importance of work environments that offer 'psychological safety' for staff to discuss in a confidential setting the circumstances of an incident that has resulted in avoidable harm. It is through a robust application of a safe space that the HSSIB will be able to command the confidence of participants and best understand the safety risks present and make appropriate recommendations.

However, there seems to us a risk in the current drafting that the exceptions on prohibition of disclosure are wide ranging, discretionary and unreasonably open to external applications for access. For example, the impact assessment published for the previous HSSI Bill in 2019 noted that, "Litigation in healthcare is a more frequent occurrence than in other areas of accident investigation. It is therefore possible that lawyers representing patients or NHS staff involved in safety incidents that have been investigated by HSSIB, may make applications for disclosure of 'safe space' information hoping to uncover material of benefit to their clients".1 The High Court's balancing test seems liable to be intrinsically balanced towards considerations of legal justice rather than systemic patient safety or learning, not least as the ability of the High Court to consider disclosure as potentially deterring information provision is questionable given that the HSSIB has powers to compel interviews and information provisions. With multiple avenues of information and powers of investigation – as well as the HSSIB's final reports being available – other bodies do not need access to protected material simply thanks to the convenience of the HSSIB's existence. As the joint committee concluded: "We recommend that the draft Bill be amended to put beyond any possible doubt that the 'safe space' cannot be compromised save in the most exceptional circumstances, and therefore that the prohibition on disclosure applies equally to disclosure to coroners".

We will seek articulation during debates in Parliament as to how the government expects these provisions to work, with examples of where disclosure may take place and the level of where the bar is set in considering disclosure. We will also seek a tighter drawing of the boundaries of safe space to ensure its appropriate preservation and in turn support participants in playing their full role in an investigation. We would suggest for example that the tests for an application to disclose protected materials must be sufficiently strong to ensure that disclosure is only sought in extremis, that there is a clear and overriding public interest in any disclosure, that the anonymity, safety and privacy of

participants is respected without exception, and that current and future investigations are not jeopardised.

Part 5: Miscellaneous

Clauses 120-129; schedule 16

Summary

Part 5 covers a range of issues. Clause 120 sets out proposals on international healthcare arrangements intended to enable the government to implement more comprehensive reciprocal healthcare agreements with Rest of World countries, subject to negotiations. Also included is a new duty on the Care Quality Commission (CQC) to conduct reviews, assess performance and publish reports on the exercise of regulated care functions by English LAs relating to adult social care and providing financial assistance to social care services. Clauses here also enable changes to be made to the professional regulation system; restrict the advertising of certain food and drink products; set minimum standards for food and drink in hospital settings; make regulations regarding food information and labelling; and introduce powers for the secretary of state to introduce, terminate or vary water fluoridation schemes.

Key clauses and NHS Providers' view

Clause 121: Regulation of local authority functions relating to adult social care

Clause 121 clause sets out a duty for the CQC to conduct reviews, assess performance and publish reports on the exercise of regulated care functions by English LAs relating to adult social care. The secretary of state will set objectives and priorities for CQC's assessments. Under the proposals, CQC would be required to set and publish indicators of quality to assess LAs' performance and prepare a statement setting out the frequency of reviews and a methodology for assessing LAs' performance, with flexibility to set different indicators, objectives and priorities for different cases. The secretary of state will have powers to direct CQC to revise its quality indicators, assessment framework, and frequency and methodology for different cases.

NHS Providers' view

We are broadly supportive of the duty for the CQC to conduct reviews, assess performance and publish reports on the exercise of regulated care functions by English LAs relating to adult social care. However, we note that this would involve the CQC becoming involved in assessing commissioning and administrative activity, potentially taking it away from its core remit of assessing the quality of services. In addition, we have questions around how the CQC would assess an LA's performance, how

they would define the link between an LA's activity and the quality of local services, and what impact these assessments would have on the quality of services being delivered.

Clause 122: Provision of social care services: financial assistance

Clause 122 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.

NHS Providers' view

This clause seeks to remove bureaucratic barriers to providing rapid financial support to a social care provider sector in exceptional circumstances, as seen during the COVID-19 pandemic. Currently, the secretary of state can only make such direct payments to not-for-profit bodies, so this clause expands existing powers to allow direct payments to be made to social care providers in England.

While we recognise the drivers behind the proposal in the Bill to provide financial support to the social care provider sector at speed in emergency scenarios, we do not think that the current Bill is the right legislative mechanism. We believe instead these powers should be incorporated into the relevant emergency legislation as temporary provisions with appropriate safeguards. We are concerned about the unintended consequences of establishing the secretary of state as a potential direct commissioner of social care providers. This risks undermining LAs' commissioning role and their knowledge of the local provider market. We are also concerned about the power it gives secretary of state to direct trusts and SpHAs to make payments to social care providers, and we do not support this approach and the implication that funding may be required from trusts.

Clause 123: Regulation of health care and associated professions

Clause 123 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. The clause also provides an updated list of the legislation that regulates professions. There is a subsection in this clause which says that this may include senior managers and leaders.

NHS Providers' view

The intention of this clause to enable broader changes to the system of regulation for healthcare professionals is welcome, as we hope it will help create a more adaptable framework of rules and processes governing the professional activities of NHS staff. We have responded positively to the government's *Regulating healthcare professionals, protecting the public* consultation which, for the

most part, sets an encouraging direction of travel towards a proportionate and flexible system of regulation which will help to ensure patient safety while better supporting the future needs of trusts as employers, and the NHS workforce as a whole.

However, we note that statutory regulation of senior managers may not resolve the issue of concern (that is, the potential for a revolving door for 'poor leaders') and is, in practice, very difficult to make effective – it will not preclude the possibility that an individual with a good track record may make a mistake, nor can it prevent non-compliant behaviour. For these reasons, we have challenged proposals to introduce regulation of senior managers. If the regulation of NHS managers is going to be pursued, we would strongly suggest that the circumstances in which the measures could be brought into statutory regulation are fully consulted upon.

Clause 124: Medical examiners

This clause amends the Coroners and Justice Act 2009 in England and allows for NHS bodies, rather than LAs, 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 for health and social care to ensure that enough medical examiners are appointed in the healthcare system in England, that 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, and to ensure that their performance is monitored by reference to any standards or levels of performance that they are expected to attain. It also introduces a power for the secretary of state to give a direction 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 such employed medical examiner, set out the means and methods that may be employed to monitor performance of medical examiners. These clauses 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.

Clause 126: Hospital food standards

This proposes to give the secretary of state powers to adopt secondary legislation that will set minimum statutory standards for food and drink provided in hospital settings.

NHS Providers' view

We support the ambition to make food in hospitals safer, healthier and more sustainable, as it is an important factor in patient recovery and wellbeing. Trusts are already working hard to ensure they meet nutritional standards and provide good quality food. Arrangements for catering within trusts vary. Some do not have the kitchen facilities to be able cater on site for patients, and so they will have

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

Part 6: General

Clauses 130-135

Summary

This chapter of clauses includes powers which allows the secretary of state, by regulations, to make provision that is consequential on this Bill. Where regulations modify primary legislation, the affirmative procedure must be used. Otherwise, the regulations can be made under the negative procedure. This provision may be used to amend primary legislation passed in any part of the United Kingdom. Where regulations are made under this Act, those regulations may make consequential, supplementary, incidental, transitional or saving provision. Provisions also sets out the territorial extent of the Bill, further financial provision necessary as a result of the Bill, and that this part of the Bill comes into force on the day that this Act is passed and that the short title of the Bill is 'The Health and Care Act 2021'.

NHS Providers' pre-legislative work

In recent months we have been working hard to influence the legislation which has been presented today. Member engagement over the last few months, underpinned by a new member reference group for the Bill, has been extremely valuable in helping to form our positions on key issues in the run up to today's publication of the Bill.

In January, following extensive member engagement, we responded to NHSE/I's *Integrating Care: Next steps to building strong and effective integrated care systems across England* consultation, welcoming the strategic direction of travel to integrate health and care at a local level through stronger collaboration and system working, but raising concerns that many significant questions regarding ICSs and their core purpose had been left unanswered. Our full response is available on our website.

In February, the government published *Integration and innovation: working together to improve health and social care for all*, setting out proposals for a Health and Care Bill. These further developed earlier proposals, as well as putting forward several new ones, as we examined in our on the day briefing. Alongside the publication of the government's White Paper, NHSE/I published five new recommendations for legislative change in regard to ICSs. Our on the day briefing is also available on our website.

We gave written and oral evidence to the Health and Social Care Select Committee inquiry on the White Paper, setting out priority issues for the committee to consider. We have engaged with politicians from all parties in the run up to Bill's publication and will continue to do so as the Bill progresses.

In the run up to the Bill's publication we pushed hard to secure small and focused stakeholder engagement groups with both DHSC and NHSE/I and played a key role in the discussions of these select groups in addition to ministerial meetings and regular bilateral meetings with senior decision makers across DHSC and NHSE/I.

Media statement

Bill signals way forward in fast changing health and care landscape

Responding to the publication of the Health and Care Bill, the chief executive of NHS Providers, Chris Hopson said:

"We welcome the publication of this Bill which will help provide clarity for trusts in a fast changing health and care landscape.

"Trusts have been at the forefront of the move towards closer collaboration and integration between health and care, a process that has accelerated in recent months to deal with the extraordinary pressures of the pandemic.

"The forthcoming legislation will formalise this process, so trusts and their partners can plan and cooperate more closely to help build healthier communities.

"We therefore think there is a lot to build on in the government's proposals, which herald the biggest reforms to the NHS in more than a decade.

"However we have been clear about key areas of concern for our members, which will need to be resolved as the Bill goes through parliament.

"It is very important to preserve the operational and clinical independence of the NHS so any new powers of direction for ministers do not impinge on issues such as procurement, treatment, drug funding and the hiring and firing of frontline NHS leaders.

"It's also important to ensure Ministers have appropriate powers in decisions over how local services are configured and that changes which improve quality and safety are not inappropriately blocked.

"There is no suggestion here that a publicly funded service like the NHS should not be held to account. Rather, that the strategic direction is the domain of politicians, who should then allow NHS leaders in operational and clinical roles - with day to day responsibility for supporting patient care - the space to deliver those strategic objectives without undue political pressure or interference.

"The new integrated care systems (ICSs) should develop to meet local needs, rather than being pushed into a one-size-fits-all approach.

"We are continuing to argue for a careful balance in how new potential controls on capital spending may be applied to foundation trusts in local systems.

"And it's vital that the legislation addresses the lack of a transparent, costed and funded long term workforce plan.

"We urge the government to continue to listen to the NHS frontline in shaping its proposals."

Wirral Community Health and Care NHS Foundation Trust

Reports from the sub committees of the Board and Informal Board - June - July 2021

Meeting	Board of Directors		
Date	04/08/2021	**Agenda item**	**9**
Lead Director	Karen Howell, Chief Executive		
Author(s)	Non-Executive Chairs of the committees		

Action required (please tick the appropriate box)

To Approve ☐	**To Discuss** ☐	**To Assure** ☑

Purpose

The reports from the sub-committees of the Board are presented as verbal updates from the Non-Executive Chairs of the committees.

The purpose of these updates is to provide a summary of the key topics discussed at each, any approvals given and to highlight any areas for escalation to the Board of Directors.

A written summary report is also provided on the bi-monthly Informal Board meetings which form part of a formal programme of informal sessions.

Executive Summary

The sub-committees of the Board meet on a bi-monthly basis with the Audit Committee meeting five times each year.

This report includes reports as follows:
Finance & Performance Committee - June 2021
Education & Workforce Committee - June 2021
Quality & Safety Committee - July 2021
Audit Committee - June 2021
Staff Council - July 2021

The report from the Informal Board meeting summarises the key topics discussed in July 2021.

Risks and opportunities:
No risks identified.

Quality/inclusion considerations:
Quality Impact Assessment completed and attached No
Equality Impact Assessment completed and attached No
The committees receive QI and EI assessments for specific programmes of work or procedural documents as they are presented. There is no assessment associated with these verbal or written updates.

Financial/resource implications:
No financial or resource implications identified.

Trust Strategic Objectives
Please select the top three Trust Strategic Objectives that this report relates to, from the drop down boxes below.

Our Populations - outstanding, safe care every time	Our People - improving staff engagement	Our Performance - delivering against contracts and financial requirements

Board of Directors is asked to consider the following action

The Board of Directors is asked to note the contents of the report and be assured by the updates provided.

Report history

Submitted to	Date	Brief summary of outcome
Board of Directors	Bi-monthly regular report to public Board of Directors	The report is received for information and assurance purposes.

Wirral Community Health and Care NHS Foundation Trust

Briefing from Informal Board Session - July 2021

Purpose

1. This is a brief report to record the key topics discussed and the information shared at an informal board session held on 7 July 2021.

Key topics discussed

2. The board session included a variety of relevant topics for discussion.

3. Following a briefing in May 2021, the Chairman and Chief Executive Officer (CEO) provided a further update on the potential implications of the White Paper *"Integration & Innovation: working together to improve health and social care for all"* and the progress to establish the ICS and ICP locally. The Chief Finance Officer/Deputy CEO provided an update on the work of the ICP delivery group in Wirral, established by CEOs to determine the governance arrangements, duties and responsibilities of the ICP and associated provider collaboratives to deliver the anticipated requirements of the reforms. A briefing on the recently published NHS System Oversight Framework 2021-22 was also provided giving members of the Board the opportunity to ask questions and understand the approach to oversight which reinforces the system-led delivery of integrated care as set out in the NHS Long Term Plan, the White Paper and as aligned with the priorities set out in the 2021-22 Operational Planning guidance.

4. The Trust's Chief Information Officer (CIO) joined members of the Board to provide a briefing on the digital aspirant journey the Trust is embarking on across Cheshire & Merseyside. This included the ambitions and timelines for the development of the Trust's Digital Strategy aligned with the Trust's 5-year strategy. The CIO provided a summary of the work on-going locally and regionally to support wider digital enablement including learning from innovations during the response to COVID-19 but also recognition of the importance of equitable access to services for all parts of the community.

5. The Director of Corporate Affairs led a session on the Board Assurance Framework presenting the proposed principal risks to be managed through the BAF during 2021-22 and beyond, as necessary. The members of the Board reflected on the useful discussions held through each of the committees of the Board to consider specific risk areas and themes. The session also included group work with Non-Executive Chairs, Executive Leads and other committee members coming together to consider the following key questions for each risk;

    - What would success look like?
    - What/where are the gaps?
    - What, therefore, is the target risk rating?
    - What are the actions and the timescales to achieve this (i.e. the trajectory)?

6. The feedback from each of the groups sessions was shared with further follow up agreed ahead of presentation of principal risks to the Board of Directors.

7. The Informal Board Programme 2021-22 plan on a page was shared with members of the Board for comment ahead of presentation for approval to the Board of Directors.

8. There were no formal recommendations and no decisions taken at the informal session. This report is provided for information.

9. The members of the Board will meet again in informal session in September 2021.

Alison Hughes
Director of Corporate Affairs

26 July 2021