House of Commons

Health and Social Care Committee

# The Government's White Paper proposals for the reform of Health and Social Care

## First Report of Session 2021–22

*Report, together with formal minutes relating to the report*

*Ordered by the House of Commons to be printed 11 May 2021*

**HC 20**
Published on 14 May 2021
by authority of the House of Commons

## Health and Social Care Committee

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# 1 Introduction

## Background

1. In February 2021, the Department for Health and Social Care published its White Paper, Integration and Innovation: working together to improve health and social care for all, setting out the Government's proposals for reform of the health and care sector. The Government's intention is to present a Bill to give effect to these proposals at the start of the 2021–22 parliamentary session. Should the Bill receive Royal Assent, implementation of the reforms will take place in 2022.

2. The Rt Hon. Matt Hancock, Secretary of State for Health and Social Care, wrote to the Chair inviting us to scrutinise the White Paper in advance of the Bill being introduced, to help inform Government thinking. Therefore, in the time available to us, we held three evidence sessions. At the first session, on 2 March, we took evidence from Richard Murray, Chief Executive, The King's Fund; Hugh Alderwick, Head of Policy, The Health Foundation; and Nigel Edwards, Chief Executive, The Nuffield Trust; Danny Mortimer, Chief Executive, NHS Confederation; Sarah Pickup, Deputy Chief Executive, Local Government Association; Sir Robert Francis, Chair, Healthwatch England; and Chris Hopson, Chief Executive, NHS Providers. The second evidence session was held on 9 March with Sir Simon Stevens, Chief Executive, NHS England; and Amanda Pritchard, Chief Operating Officer, NHS England and NHS Improvement. At the final session we took evidence from Rt Hon Matt Hancock, Secretary of State for Health and Social Care and Jason Yiannikkou, Director of NHS Legislation Programme at Department of Health and Social Care. We thank them for the evidence they gave and the insights they had on the proposals.

3. Given the time constraints, we focussed on the purpose of the reforms, patient choice and potential implementation (Chapter 2), Integrated Care Systems (Chapter 3), social care (Chapter 4), workforce planning (Chapter 5), additional powers for the Secretary of State (Chapter 6), public health (Chapter 7) and proposals to reduce bureaucracy and increase innovation (Chapter 8).

# 2 The White Paper

## Introduction

4. The White Paper, Integration and Innovation: working together to improve health and social care for all, describes the Government's proposals as "backing our health and care system and everyone who works in it".[1] The Forward of the White Paper states that this would be done by:

- Removing the barriers that stop the system from being truly integrated through a greater role played by Integrated Care Systems (ICS);
- Removing transactional bureaucracy; and
- Ensuring that the health and care system is "more accountable and responsive to the people that work in it and the people that use it".[2]

5. The White Paper states that the benefits of the proposals are as follows:

> Integrating care has meant more people are seeing the benefits of joined up care between GPs, home care and care homes, community health services, hospitals and mental health services. For staff, it has enabled them to work outside of organisational silos, deliver more user-centred and personalised approaches to care, and tackle bureaucracy standing in the way of providing the best care for people.[3]

6. The overarching aims of the proposals received a positive response from a wide range of organisations and stakeholder bodies. The Royal College of General Practitioners said it was "broadly supportive" of the aims of the White Paper[4] and this was echoed by, among others, the Royal College of Nursing,[5] the British Medical Association[6] and National Voices.[7] In particular, the proposal to put Integrated Care Systems on a statutory footing received support from the Royal College of Physicians,[8] the Royal College of Radiologists,[9] the Allied Health Professionals Federation,[10] the Faculty of Sexual and Reproductive Healthcare[11] the Royal College of Obstetricians and Gynaecologists and the Association of Dental Groups.[12]

7. However, as with many submissions to this inquiry, Carers UK's support for the aims of the Bill were caveated with concerns about omissions in the White Paper and areas that required further detail.[13]

1 White Paper, Forward
2 White Paper, Forward
3 White Paper, Executive summary, 1.9
4 The Royal College of General Practitioners (HSC0950)
5 Royal College of Nursing (HSC0916)
6 BMA (HSC0873)
7 National Voices (HSC0979)
8 The Royal College of Physicians (HSC0934)
9 The Royal College of Radiologists (HSC0929)
10 Allied Health Professions Federation (AHPF) (HSC0774)
11 The Faculty of Sexual and Reproductive Healthcare and The Royal College of Obstetricians and Gynaecologists (HSC0795)
12 Association of Dental Groups (HSC0024)
13 Carers UK (HSC0942)

8. Support for the aims was also evident from our witnesses from stakeholder organisations and academic institutions, all of whom welcomed the direction of travel. The King's Fund said that the proposals represented "a welcome shift in emphasis towards more integrated working", and supported the proposed duty for organisations to collaborate.[14] In a similar vein, the Health Foundation stated that the "emphasis on collaboration between the NHS, local government, and others" was welcome.[15]

9. Stakeholder organisations were also in favour of the change in approach. The Local Government Association believed that the White Paper was:

> A promising base on which to build stronger working relationships between local government and the NHS, as equal partners, to address the wider determinants of health and deliver better and more coordinated health and care services.[16]

In particular, the LGA welcomed the renewed focus and commitment on existing local partnerships and accountability, especially at "place level" and the "creation of an ICS Health and Care Partnership to work alongside statutory NHS bodies".[17]

10. The NHS Confederation strongly supported the direction of travel, asserting that it was "the right approach for improving care to the public and value for money for the taxpayer".[18] NHS Providers also saw the proposals as providing "an important opportunity to accelerate the move to integrate health and care at a local level, replace competition with collaboration and reform an unnecessarily rigid NHS approach to procurement".[19]

11. Many of the proposals came at the request of NHS England in a process that started in 2014.[20] Sir Simon Stevens explained that the White Paper was the result of "an evolution that has been under way across the health service for at least the last seven or eight years" in which the NHS had worked with a wide range of stakeholders and other organisations to "change the reality" of frontline care. He told us that around 85% of the content of the White Paper came from the proposals that the NHS had consulted on and was requesting. He concluded that the thrust of the White Paper had the support of the NHS and that the proposals "go with the grain of what people across the health service want to see".[21]

12. When he came before us, the Secretary of State, Rt Hon Matt Hancock, reiterated that the high-level purpose of the proposals was to strengthen integration, reduce bureaucracy, and strengthen accountability in the NHS and that they would "build on the best practice that is already out there when systems work together".[22]

13. **We support the proposals in the White Paper that will be included in the new Bill and welcome the direction of travel in the Government's reform of health and social care. Provided that proper accountability mechanisms are put in place, particularly relating to the safety and quality of care, we believe that creation of Integrated Care**

14 King's Fund (HSC001)
15 Health Foundation (HC0004)
16 Local Government Association (HSC0011)
17 Local Government Association (HSC0011)
18 NHS Confederation (HSC0005)
19 NHS Providers (HSC0003)
20 Q77
21 Q79
22 Q135

**Systems throughout England has the potential to improve the delivery of care services for patients. However, there are areas in the White Paper that require further clarity or revision—and some concerning omissions which we set out in the subsequent chapters of this Report.**

14. In the rest of this chapter we pick out two particular factors which will be critical to the success of the proposals within the White Paper as a whole: patient choice and Care Quality Commission ratings of ICSs.

## Patient choice

15. The White Paper proposes placing a duty on ICSs to facilitate patient choice in relation to services and treatment.[23] In written evidence to us, the King's Fund highlighted improving the patient experience as a key test for the reforms; and stated that it would be "important to develop a strong narrative around the benefits the reforms will bring to patient care".[24] In a similar vein, the NHS Confederation highlighted the importance of protecting and promoting patient choice in order to "avoid local monopolies by continuing to work effectively […] with independent and voluntary sector providers, as well as social enterprises."[25]

16. However, in written evidence the Patients' Association were concerned about how patients would be involved in the reforms. It argued that the White Paper contained "no vision for patients having any meaningful role in the planning or running of NHS services" and that there were "no firm proposals or commitments" to address this.[26] Healthwatch also stressed that for ICSs to make "good, well-informed decisions" it was vital that local people had a way of formally inputting into the process.[27] Healthwatch also emphasised the need to facilitate patient choice for disadvantaged communities and for other groups such as parents. The Royal College of General Practitioners also noted that reform would not deliver the intended outcomes unless there was an appropriate level of focus on "facilitating collaboration between clinicians and patients".[28]

17. The Nuffield Trust also saw the effect of the reforms on patients as a key test and emphasised that the Bill, when presented to Parliament, needed to retain the 'Any Qualified Provider' model for elective care, where "commissioners fund any organisation meeting standards which provides elective care at a rate per patient who chooses that provider, and the legal right of choice for a first appointment".[29] The importance of patient choice was also highlighted by the British Dental Association who believed that services needed to be delivered locally wherever possible and that patients must be able to seek treatment across ICS and Primary Care Network boundaries.[30]

23 White Paper, para 5.37
24 King's Fund (HSC001)
25 NHS Confederation (HSC0005)
26 The Patients Association (HSC0892)
27 Healthwatch (HSC0006)
28 The Royal College of General Practitioners (HSC0950)
29 Nuffield Trust (HSC0002)
30 British Dental Association (HSC0955)

18. When we questioned Sir Simon Stevens on this, he agreed that the ability for patients to have the choice as to where they receive their care, both *within* an ICS area and *outside* of it [our italics] had to be retained.[31] This was echoed by the Secretary of State when he gave evidence to us. He said that retaining choice was "very important" and that the "fundamental split between commissioning and provision of services" would remain.[32]

19. **We welcome the Secretary of State's confirmation that the statutory right of a patient to choose where they receive treatment will be retained in the forthcoming legislation. We welcome the Secretary of State's commitment to this and look forward to seeing provisions in the Bill to maintain and enhance patient outcomes and to retain the patient's right to receive treatment outside the area served by their local ICS.**

## Care Quality Commission rating of ICSs

20. Assessing the effectiveness of Integrated Care Systems will be a key part on judging the success of the proposed reforms. When we put it to Sir Robert Francis, Chair of Healthwatch, that the Care Quality Commission (CQC) should rate ICSs he agreed that this would be a positive step and that there were two audiences for ratings, "one is the taxpayer and those that represent the taxpayer. Are we getting what we are paying for?"[33]

21. Chris Hopkins noted that the CQC had played a valuable role in system reviews and that it made sense to use the CQC for assessing ICSs,[34] and Danny Mortimer agreed that "ICSs absolutely need to be held to account". He also noted that:

> The conversations that we have had over recent months with both NHS England and the CQC have given us some assurance that those organisations recognise that they need to revisit and change their ways of working.[35]

22. Sir Simon Stevens was also receptive to the CQC providing Ofsted-style ratings and highlighted the "important" developments of the CQC inspection regime in relation to its thematic reviews. He asserted that "having that focus across individual providers in the ICS will be of great value". He further noted that any CQC review of the ICS would need to focus on "mandate goals and the long-term plan deliverables that have been set, so that there is complete accountable alignment through the service".[36]

23. In response to this suggestion, the Secretary of State confirmed that the Government would "ensure, as part of the Bill, that the CQC will be able to inspect how well systems are doing and publish on that basis, including setting out the high-level, four-part report—Outstanding, Good, Requires Improvement and Inadequate—that everybody knows and understands".[37]

24. **We welcome the Secretary of State's commitment to include in the Bill, at our suggestion, provisions to enable the Care Quality Commission to undertake ratings of Integrated Care Systems. As an independent regulator it must for the CQC to decide how such inspections and ratings work but we note that the success of the system to date**

31 Q86
32 Q155
33 Q31
34 Q33
35 Q35
36 Q81
37 Q135

**has been partly because the core domains (safe, effective, caring, responsiveness and governance) are largely patient-facing, so it is essential such an approach is maintained including a domain that focuses on safety and quality and is named as such. We believe within these domains it should be possible to include assessment of delivery of core NHS England and DHSC objectives so that there is alignment of objectives across the system.**

25. ***We recommend that the CQC's assessment of ICSs includes consultation with patient groups and consideration of patient outcomes, and that all relevant data is published.***

26. ***We further recommend that the CQC rating includes progress ICSs make on the integration of information technology between primary care, secondary care and the social care sector.***

## Implementation

27. The White Paper envisages that the reforms contained in the White Paper would be implemented in 2022. Given the exceptional strain that has been placed on the NHS and local authorities during the covid-19 pandemic, a number of our witnesses questioned the need to set what they considered to be a challenging implementation timeframe. The Nuffield Trust highlighted the 2022 timetable, in the context of the very "serious operational challenges the NHS is likely to see".[38] The Health Foundation agreed. It described the challenges facing the NHS after covid-19—the backlog of unmet health care need, fixing chronic staffing issues, and working with others to tackle wide and unjust health inequalities—as "staggering".[39] NHS Providers also argued that the Government needed to "reflect on the appropriateness of changing the structure of the NHS at a time when it is operating on a crisis footing when frontline staff need absolute clarity about ways of working" and urged the Department and NHSE/I to "seriously consider extending the timetable for developing and implementing these proposals",[40] in light of what is an "extremely challenging time for the NHS" with Trusts needing to "stabilise the service and recover the care backlog".[41]

28. In its submission, the British Medical Association highlighted that the reforms would be introduced at a time when the NHS was experiencing unprecedented pressures; and that "proposals for reorganisation on such a scale must be given time and space to get right and not be rushed through while doctors are still dealing with the aftermaths of a worldwide pandemic".[42] The effect of implementing the reforms in the context of the pandemic was also raised by the British Dental Association[43] and the Chartered Society of Physiotherapy[44] and Professors Judith Smith, Jon Glasby and Robin Miller at the University of Birmingham.[45]

38 Nuffield Trust (HSC0002)
39 Health Foundation (HC0004)
40 NHS Providers (HSC0003)
41 NHS Providers (HSC0003)
42 BMA (HSC0873)
43 British Dental Association (HSC0955)
44 The Chartered Society of Physiotherapy (HSC0927)
45 Professor Judith Smith, Professor Jon Glasby and Professor Robin Miller at the University of Birmingham (HSC0868)

29. However, although the NHS Confederation believed that the Government needed to be "mindful of the timeline for implementing [the] measures" it argued that many of the proposals in the White Paper would "merely formalise how our members are increasingly operating."[46] This view was supported by Sir Simon Stevens who argued that the timing of the proposals and the implementation were both necessary and achievable:

> Yes, as the NHS we would ask that Parliament gives attention to this matter during the course of the coming year. The reason is that it is not coming from a standing start. It is almost the concluding stage of an evolution that has been under way across the health service for at least the last seven or eight years. It began back in 2014 with the NHS five-year forward view.[47]

Sir Simon confirmed that the NHS had "done nine tenths of what we are able to do", but that the final tenth "requires changes to the 2012 Act, to get rid of some of the fragmentation".[48] He concluded that this was why the NHS was seeking approval to make those changes in the proposed timeframe.[49] For some areas this would be easier than others. Amanda Pritchard, Chief Operating Officer, NHS England and NHS Improvement, explained that different parts of England would be starting at different points:

> For some parts of the country that have been on this journey, and been very serious about integration, for some time, it removes the remaining barriers for them, to make it as easy as possible. For other places, it is much more about putting some of the foundations in place.[50]

On the timing of the reforms, the Secretary of State reiterated that "the vast majority" of the proposals came from NHS and reflected the needs of local authorities. For that reason, he saw no benefit in delaying the process.[51]

30. **While we accept the importance of the timely implementation of the proposed Bill, we recognise the concerns raised by our witnesses about the effect this may have on the NHS and the care sector; both of which have been put under unprecedented strain during the covid-19 pandemic. The Government must be alive to the need for flexibility in the timetable for implementation as the scale of the post-pandemic backlog becomes clearer.**

31. ***Different parts of England will be further along the journey towards integration than others. In order for all areas to benefit from Integrated Care Systems, we recommend that:***

a) ***The Department and NHS England ensure that processes are in place to share best practice quickly and effectively so that all areas can implement these reforms efficiently, with additional practical support mechanisms offered to ICSs that get low CQC ratings;***

b) ***The implementation period takes into account fully, the fact that parts of the country will be at different starting points on this journey; and***

46 NHS Confederation (HSC0005)
47 Q77
48 Q77
49 Q77
50 Q85
51 Q180

c) ***Local NHS leaders have a role in setting the pace of the implementation to ensure that the establishment of ICSs will not adversely impact an area's covid-19 response or recovery.***

# 3 Integrated Care Systems

## Integrated Care Systems

32. At the heart of the Government's reform of health and social care is the proposal to place Integrated Care Systems (ICSs) on a statutory footing with a "broad duty to collaborate", and a "triple aim duty" to pursue:

- Better health and wellbeing for everyone;
- Better quality of health services for all individuals; and
- Sustainable use of NHS resources.[52]

33. Every part of England will be covered by an ICS that will bring together NHS organisations, local government and wider partners at a system level.[53] The ICS will comprise:

- An Integrated Care System Body, that will be responsible for developing a plan to meet the health needs of the population within their defined geography; developing a capital plan for the NHS providers within their health geography; and securing the provision of health services to meet the needs of the system population[54]
- An Integrated Care System Health and Care partnership, that will be responsible for bringing together systems to support integration and develop a plan to address the areas health, public health and social care needs.[55]

34. The ICS NHS Body will also merge the functions of non-statutory STPs/ICSs with the functions of a CCG.[56] Flexibility will be a key part of the proposals to ensure that ICSs can develop their own processes, structures and decision-making procedures.[57]

35. Placing ICSs on a statutory footing, and assigning them clear duties will, the Department states, deliver more efficient and more collaborative health and social care services to local populations. The Health Foundation, however, noted while legislation is necessary, "making collaboration work depends as much on culture, management, resources, and other factors as it does on NHS rules and structures".[58] The King's Fund agreed, noting that the success of the reforms would be "critically dependent on culture and behavioural change" rather than on legislation.[59]

52 White Paper, para 3.11
53 White Paper, Page 3.8
54 White Paper, para 5.7
55 White Paper, Page 19
56 White Paper, Page 31, para 5.8
57 White Paper, Page 32, para 5.9
58 Health Foundation (HSC0004)
59 King's Fund (HSC001)

## Challenges for ICSs

36. Our witnesses and those organisations that submitted written evidence were broadly supportive of the establishment of statutory ICS NHS bodies and Health and Care Partnerships. However, for many, the success of the new bodies would be dependent on the Bill setting out in detail how they would work together, their powers and the composition of their boards.

37. As our witnesses highlighted to us, the quality of the relationship between the NHS ICS Body and the Health and Care Partnership was central to the overall effectiveness and success of the new ICSs. The Nuffield Trust highlighted the potential risk that ICSs could become NHS focused to the detriment of wider collaboration and that the dominance of an NHS Trust in terms of size and funding could "unbalance priorities and create unintended conflicts of interest, especially when they take on the responsibilities of CCGs for selecting providers and giving out money".[60] This concern was also raised by the Kings Fund who believed that there was a risk that ICS Health and Care Partnerships may lack the powers to drive change and that the ICS NHS Body could be "too narrowly focused on the NHS at the expense of other partners".[61]

38. The King's Fund also identified a risk that ICS bodies may "inadvertently drag attention away from the more local 'place' level where collaboration can be most fruitful" and emphasised the importance of ICSs "building up from 'places'."[62] It believed that the Government needed to provide greater clarity on how the plans of the ICS NHS Body and the ICS Health and Care Partnership; and joint health and wellbeing strategies from Health and Wellbeing Boards at the more local place level will be aligned to ensure that there is no duplication or overlap.[63]

39. NHS Providers said that while they understood the rationale behind the proposed two-part statutory model for ICSs, there was an enduring concern about "the distinct probability of unclear and duplicate accountabilities between the various bodies already in existence".[64] For that reason, it argued for greater detail on how "the different bodies, their roles and accountabilities fit together without duplication or overlap".[65]

40. In its written submission, the Policy Research Unit in Health and Care Systems and Commissioning emphasised the need for further detail and guidance in relation to decision-making, governance and accountability structures; and the mechanisms that will be put in place to avoid conflicts of interest.[66] The Chartered Institute of Physiotherapy was also concerned that the NHS ICS Body had the potential to become too narrowly focused on the NHS if the ICS Health and Care Partnership lacked the necessary powers to drive change.[67] The Royal College of General Practitioners also noted this risk where the organisational culture within an ICS was not well established, or where the interests and accountabilities of large and powerful organisations could overtake the aims of the wider system.[68]

60 Nuffield Trust (HSC0002)
61 King's Fund (HSC001)
62 King's Fund (HSC001)
63 King's Fund (HSC001)
64 NHS Providers (HSC0003)
65 NHS Providers (HSC0003)
66 The Policy Research Unit in Health and Care Systems and Commissioning (HSC0748)
67 The Chartered Society of Physiotherapy (HSC0927)
68 The Royal College of General Practitioners (HSC0950)

41. The Royal College of Physicians noted the varying level of development of ICSs across England and that it would be important that both support and guidance was provided to "fledgling" new bodies to enable them to "learn from those that are more established and more experienced".[69] It also wanted to see greater clarity on the relationship between the two new bodies to ensure that all stakeholders are meaningfully involved and that voices outside the NHS are heard.[70]

42. In relation to guidance, the Local Government Association stressed the importance of it being produced as a partnership between central and local government and sought "a commitment on the parliamentary record" to that effect.[71] It further argued that any future accountability mechanisms built on and enhanced existing local democratic accountability and that "local government needs to remain directly accountable to our residents".[72]

43. Sir Simon Stevens acknowledged the need to ensure accountability and the importance of providing guidance and support. However, he cautioned against over-prescription in this regard, in favour of "a permissive framework that enables sensible local judgments to be made."[73] Amanda Pritchard said that the benefits of the proposals were to enable ICSs to "understand the local needs of your population, and design services that bring together primary care, community, acute, mental health, and partners, to best meet the needs of the population".[74] As examples she cited the ability to:

- Run single waiting lists across an integrated care system, rather than being reliant just on the resources of an individual hospital,
- Prioritise care for those who most need it, across a much wider geography through cancer hubs, surgical hubs, or more specialist services.[75]

44. Amanda Pritchard also said that ICSs would also build on the co-terminosity seen in the last year and the "strength of the relationship between local government and the NHS".[76] She added that the proposals in the White Paper should deliver a "permissive framework, with a set of principles that then guide local decision making" which would give stakeholders "the space locally to make sure that they have an outcome […] that really works for the local population and for the local situation".[77]

45. **The success of ICSs will, in no small part, be dependent on good working relations between the NHS Body and Health and Care Partnership. While we agree with Sir Simon Stevens that the proposals provide flexibility for local decision-making, clear lines of accountability will be necessary to ensure that both component parts of an ICS can function efficiently and effectively.**

69 The Royal College of Physicians (HSC0934)
70 The Royal College of Physicians (HSC0934)
71 Local Government Association (HSC0011)
72 Local Government Association (HSC0011)
73 Q80
74 Q85
75 Q85
76 Q80
77 Q80

46. ***We therefore recommend that the Government include in the Bill a more detailed framework that sets out the roles and responsibilities of both the NHS Body and the Health and Care Partnership and of the Chair of the ICS. NHS England should set out in guidance how the responsibilities and accountabilities of NHS trusts and foundation trusts align with these to avoid confusion, duplication or overlap.***

## Appointment of board members of the statutory bodies

47. The Health and Care Bill provides the Government with an opportunity to reform the procedures for appointing individuals to NHS boards. In relation to the new NHS Body and the Health and Care Partnership Body, Sir Simon Stevens agreed that it would be important to provide guidance on the appointment of board members but cautioned that such guidance should not be "too prescriptive" because there were a "different set of arrangements, challenges and partners in different parts of the country".[78] Amanda Pritchard agreed, stating that guidance was "the absolute minimum that you would expect to see around the governance table" and that it would set a "minimum expectation" for the governance of boards.[79]

48. In addition, we tested the need to introduce a reformed fit-and-proper person test for the appointment process. Sir Simon agreed that the Bill presented an opportunity to introduce a reformed UK-wide fit and proper person register for appointments to ICS boards.[80] Amanda Pritchard argued that "appropriate and adequate mechanisms" were required where "things have gone very wrong".[81]

49. When we discussed this with the Secretary of State, he confirmed that he was "open" to the suggestion that the Bill could include reform of the fit-and-proper-persons test for people appointed to the ICS boards.[82] Jason Yiannikkou, Director of NHS Legislation Programme at Department of Health and Social Care, explained that the Department would be bringing forward an enabling power that would "facilitate options in this space", but cautioned that the Department needed to "wait for the work to be taken forward".[83] In addition, the Secretary of State explained that the Bill would also provide him with a power of veto for board Members meaning that they would be joint appointments between the Secretary of State and the NHS.[84]

50. Other witnesses highlighted the importance of clarity in relation to the composition of boards. Carers UK believed there should be "clear and explicit references to carers" in any duty for the new bodies to consult with patients and communities,[85] and that there should be a carer representative on the key decision-making bodies.[86] Healthwatch also were in favour of a wide range of representation on boards. While it welcomed the White

78 Q88
79 Q88
80 Q89
81 Q90
82 Q156
83 Q156
84 Q157
85 Carers UK (HSC0942)
86 Carers UK (HSC0942)

Paper's explicit reference to involvement of Healthwatch in the new systems, it set out how it believed that involvement should work. Healthwatch argued that the Bill need to clearly set out a non-voting, independent role for Healthwatch on the ICS governance boards.[87]

51. The King's Fund noted that the White Paper did not contain detail on "precisely who will be on the boards". In a similar vein, there is little detail on the appointment process in relation to the boards. When we questioned the Secretary of State, he explained that the proposed approach on appointments was that "NHSE would make appointments, but they would need to be signed off by the Secretary of State" and that this was "effectively moving appointments to joint appointments". The Secretary of State also confirmed that his office would have "a power of veto" for chairs of boards.[88] A number of our witnesses raised concerns about the potential politicisation of the NHS as a result of the proposed powers to be given to the Secretary of State and the power to appoint and veto raises similar concerns.

52. **It is vital that local populations have confidence in the boards of the NHS Body and the Health and Care Partnership and transparency in the appointment process for those boards will be a key factor in that. If NHS Bodies and Health and Care Partnerships are to be successful they must not be dominated by the views of the NHS but draw on the experience and expertise in all areas of the health and care sectors as equal partners.** ***We therefore recommend that a duty be placed on ICS boards to ensure that:***

a) ***the composition of boards includes representatives with experience and expertise in the views and needs of patients, carers and the social care sector.***

b) ***where an ICS's decision-making affects carers and the social care sector, that the ICS undertake formal consultation with the groups and sectors affected.***

53. **The White Paper will give the Secretary of State the ultimate responsibility for appointments to NHS boards. Given the concerns about the potential politicisation of the NHS, there will need to be full transparency in the appointment process.** ***We therefore recommend that the Bill sets out the criteria by which the Secretary of State will use this power so that appointments and vetoes decided upon can be assessed.***

54. **We conclude that the Bill provides a timely vehicle to introduce reforms to the fit-and-proper persons test for appointments to NHS boards.** ***We therefore recommend that the Bill is used to establish a UK-wide public register of people that are holding, have held, or are seeking to hold a position on an NHS board. We also recommend that NHS England and the Department undertake a review of the adequacy of the training and support provided to board members.***

87 Healthwatch (HSC0006)
88 Q157

# 4 Proposals for Social care

55. The executive summary of the White Paper states that "the Department recognises the significant pressures faced by the social care sector and remains committed to reform," and that the Government is "committed to bringing forward proposals this year [2021]".[89] However, we note that the Queen's Speech did not include detailed plans for social care reform and we will be extremely disappointed if these plans are not brought forward by the end of the calendar year. Although there is no detail on the long-term reform of social care, the White Paper does contain a number of specific and targeted social care changes including:

- The power for the Secretary of State to make payments directly to adult social care providers.[90]
- Adult social care to be given a "more clearly defined role within the structure of an ICS NHS Board.[91]
- The introduction of a new Assurance Framework for Social Care including a duty on the CQC to assess local authorities' delivery of adult social care and a power for the Secretary of State to intervene where the CQC finds that a local authority is failing to meet its duties.[92]
- The introduction of a legal framework for Discharge to Assess to enable assessment to take place after an individual has been discharged from acute care.[93]

56. A significant number of submissions to our inquiry pointed out that the White Paper did not address the urgent need for a long-term plan for social care. Below is a selection of extracts that focus on the absence of that plan:

- The most glaring omission from the White Paper is a clear plan for reform of the funding of social care, and likewise of measures to address the highly constrained capacity of social care provision and workforce (Professor Judith Smith, Professor Jon Glasby and Professor Robin Miller at the University of Birmingham).[94]
- We were disappointed that the White Paper missed the opportunity (yet again) to make wider reforms to the social care system or set out its proposals for the public health system (Allied Health Professions Federation).[95]
- These reforms to health and care must go hand-in-hand with wider social care reforms which lead to significant, permanent, and sustainable funding (Carer's Trust).[96]

89 White Paper, Executive summary
90 White Paper, para 5.96
91 White Paper, para 5.100
92 White Paper, para 5.108
93 White Paper, para 5.113
94 Professor Judith Smith, Professor Jon Glasby and Professor Robin Miller at the University of Birmingham (HSC0868)
95 Allied Health Professions Federation (AHPF) (HSC0774)
96 Carer's Trust (HSC0028)

- The proposals do not address the urgent need to put social care on a sustainable, long-term financial footing (Local Government Association).[97]

- The CSP is concerned about the omission of long overdue social care funding and reform in the White Paper (Chartered Institute of Physiotherapy).[98]

57. The absence of a long-term settlement for social care was also a concern for our witnesses from academia and stakeholder organisations. The King's Fund highlighted to us that the White Paper's proposals were predominantly reforms to the NHS and that the White Paper did not "commit to the long promised and overdue plans to reform the adult social care system".[99] As a result, it argued that the White Paper did not provide a "clear overall vision" for the three arms of the health and care system, namely the NHS, public health and social care".[100]

58. Witnesses also noted that the absence of a funding settlement had the potential to unbalance the work of ICSs. For example, the Health Foundation noted "without additional funding or a comprehensive plan for reform, the fundamental issues in social care remain"; and that further delays meant that the Government was "choosing to prolong one of the biggest public policy failures of our generation". Similarly, The Nuffield Trust also asserted that the White Paper "does nothing to meet the Government's explicit promises of meaningful reform".[101] NHS Providers also emphasised the importance of properly funding and reforming the social care system, while the NHS Confederation argued that detail on what that reform would look like was required "as a matter of urgency".[102]

59. Commenting on the absence of a long-term plan for social care, Sarah Pickup from the Local Government Association stressed that the long-term plan for health, and the aspirations for health, "can only be delivered if social care and other public services like housing and public health services are developed and funded appropriately in line."[103]

60. Sir Simon Stevens said that the NHS supported the need for proper reform of a "well-funded adult social care system" and that it had been making that case for that for "some time".[104] However, he argued that "pragmatically" he wanted to "get on with making the changes that are set out in the White Paper" which he believed provided a "better docking mechanism for a reformed adult social care system".[105] That said, Sir Simon noted the importance of adequate funding for social care and that it was "vitally important that social care can be there as equally resourced partners in that journey as well".[106]

97 Local Government Association (HSC0011)
98 The Chartered Society of Physiotherapy (HSC0927)
99 King's Fund (HSC001)
100 King's Fund (HSC001)
101 Nuffield Trust (HSC0002)
102 NHS Confederation (HSC0005)
103 Q52
104 Q107
105 Q107
106 Q113

61. When we questioned the Secretary of State on the absence of a long-term plan for social care, he said that the White Paper reforms would deliver "better integration with the health service" that would help. However, he acknowledged that there were broader questions around the long-term funding for social care that had yet to be answered.[107] He went on to explain that reform and funding would be addressed in a separate White Paper and would be legislated separately from the current proposals.[108]

62. We also questioned the Secretary of State on the absence of any reference to unpaid carers.[109] In a written response, the Secretary of State acknowledged the "essential role" that unpaid carers played in ensuring the health and wellbeing of others and that they were "a highly significant contributor to the wider care system".[110] He said the Committee had raised "a number of important questions" about the role and representation of carers in his Department reforms and as a result he had instructed his officials to "examine these in detail, to consult further with Carers UK and other carers organisations and to see what more we can do".[111]

63. Recently, the Chair of our Committee has pressed the Government to commit to a fully funded settlement for social care—in line with the recommendations of our Report, Social care: funding and workforce.[112] At the Liaison Committee meeting on 24 March 2021, he pressed the Prime Minister on reform and funding for social care. In response the Prime Minister confirmed that the Government would be bringing forward a 10-year plan "later this year".[113] However, in response to an Oral Question on the same subject from the Chair on Tuesday 13 April, the Secretary of State for Health and Social Care did not provide any further details:

> We are working hard, including with stakeholders, and the Minister for Care has held a number of roundtables on the subject. We want this to be an open and broad programme, to ensure that we get the right answers to these long-standing questions.[114]

64. **We were concerned that the White Paper did not set out a long-term plan for social care. The absence of a fully funded plan for social care has the potential to destabilise Integrated Care Systems and undermine their success. However, we note that the Prime Minister has committed the Government to producing a 10-year plan later this year; and we would be extremely disappointed if detailed plans for this were not published before the end of the calendar year. It is vital that this plan is fully costed and funded at the levels set out in our Report, Social care: funding and workforce. Without secure, long-term funding, the problems that have bedevilled the care sector over the last two decades will not be solved.**

65. ***The social care sector needs reassurance that both the structural and financial problems it faces will be tackled by the Government in a timely way. For that reason, we recommend that a duty is included in the Bill for the Secretary of State to publish a 10-year plan with detailed costings within six months of the Bill receiving Royal Assent.***

107 Q178
108 Q178
109 Q179
110 Letter from the Secretary of State, dated 7 April 2021
111 Letter from the Secretary of State, dated 7 April 2021
112 Third Report from the Health and Social Care Committee, HC206 of Session 2019–21
113 Oral evidence: Evidence from the Prime Minister, HC 1285, Q37
114 HC Deb, Tuesday 13 April 2021, col 133

66. ***Unpaid carers are partners in care and it is deeply concerning that the White Paper does not mention unpaid family carers at all. We welcome the commitment by the Secretary of State to consider what support and representation can be given to unpaid carers, and recommend that the NHS should have a responsibility to have regard to carers and to promote their health and wellbeing. This should be included in the Bill. We further recommend that provisions to protect carers' rights on discharge also be included in the Bill.***

## CQC rating of local authority provision

67. One of the specific proposals on social care is the introduction of a new Assurance Framework for social care including a duty on the CQC to assess local authorities' delivery of adult social care. This proposal received a mixed response from our witnesses. The Nuffield Trust broadly welcomed this proposal but thought that it "misses an opportunity to bolster the CQC's role in regulating the provider market".[115] Nigel Edwards from the Nuffield Trust was also concerned about the state of the provider sector which he described as "fragmented, and often quite financially precarious".[116] He noted that the CQC already had an oversight role in relation to social care and that was an infrastructure that could be built on. However, he argued that "the White Paper proposals, as they are currently put, would not solve that particular problem".[117] Furthermore, Nigel Edwards believed that without fundamental change in the nature of the funding and the social care system the proposal would result in local authorities "effectively being set up to fail".[118]

68. The Local Government Association made clear to us that the proposals in the White Paper, "have not been subject to public consultation or engagement" and called on the Government to commit to:

> An inclusive consultation and engagement on any proposals that have not previously been in the public domain. These changes will impact some of the core functions of local government, so it is crucial the sector is fully engaged.[119]

It also described as "disappointing" that the Government's immediate priority for social care was to strengthen national oversight of care and support, rather than bring forward its long-awaited wider funding reforms.[120] In evidence to us, Sarah Pickup reiterated the LGA's position, stating that the proposals were for "more assurance of a system that is not funded to deliver its responsibilities as set out in the Care Act."[121] She agreed that assurance and transparency in the adult social care system was important but stressed to us that it was already "locally accountable to democratically elected councillors" and that part of the assurance must not be ignored.[122]

115 Local Government Association (HSC0011)
116 Q17
117 Q17
118 Q18
119 Local Government Association (HSC0011)
120 Local Government Association (HSC0011)
121 Q55
122 Q55

69. Richard Murray, Chief Executive of the King's Fund, agreed. He did not believe that intervention was answer to either the "question of social care" or "question of integration".[123] Although he saw merit in either the CQC or local authorities regulating the provider market, he argued that the proposals were an example of "trying to use regulatory levers for something that is not a regulatory issue".[124] In particular, he argued that when the Secretary of State intervened in Trusts it was not as a result of "bad management" but as a result of "being asked to do things they could not do".[125]

70. Hugh Alderwick, Head of Policy at the Health Foundation, also asserted that the proposals represented a topdown performance management for a system that was being set up to fail.[126] Although he agreed that there was a role for "stronger national support for learning improvement in the sector", intervention and stronger national oversight would not solve the systemic problems around funding and pay in the system and he believed that the focus of intervention should be on "Government to release the funding to support the system effectively".[127]

71. Sir Simon also noted the proposal for the CQC to rate local authority provision but stressed that it was a matter for the Government and fell outside of the recommendations made by the NHS.

72. **The involvement of the CQC in Ofsted-style rating of social care provision by local authority area would create parity in accountability with the new ICSs and shine a much-needed light on local variation in the provision of social care. However, for this to be successful the social care system needs to have in place a fully funded 10-year plan to sit alongside the NHS's own 10-year plan.**

73. ***We recommend that, following consultation with local government on its implementation, the Bill gives the CQC powers to give Ofsted-style ratings for local authority social care.***

74. ***We further recommend that the CQC ratings includes consideration of food standards in social care settings to better align social care and the NHS in relation to the proposals in the White Paper on food and nutrition standards in the NHS.***

75. ***We recommend that the new Bill gives the CQC powers to give Ofsted-style ratings for local authority social care provision but that these are not enacted until the 10 year social care plan is published later this year and there has been full consultation with local government.***

123 Q20
124 Q21
125 Q20
126 Q22
127 Q22

# 5 Workforce

76. The pressures created by staffing shortfalls and the effect such shortfalls have on patient care is an area of keen interest for our Committee. Our inquiry into Workforce burnout is considering the wider issues involved so we do not cover them here. Rather, we focus on the key proposal in the White Paper to place a duty on the Secretary of State for Health and Social Care to publish a document, once every 5 years, which sets out roles and responsibilities for workforce planning and supply in England.[128]

77. Workforce planning is a key component in ensuring that the NHS can meet the demand for its services without overloading the staff that work in it. For that reason, our witnesses were underwhelmed by the proposed duty to provide an update only once a Parliament. In written evidence, the King's Fund described the proposed duty as "wholly inadequate". It argued that:

> The government could, for example, require national workforce strategies for the NHS and social care, together with arrangements for reporting progress.[129]

78. In oral evidence, Richard Murray from the King's Fund explained that the workforce plan needed to combine measures required in the shorter term to support employers to improve retention and to improve people's skills in the workforce and in the longer term to ensure new training and increases of supply in the workforce.[130] He argued that what was needed was a "wider health and care approach to the workforce that balanced both the short term and the long term.[131] In a similar vein, the BMA argued that the Secretary of State's duty to report on roles and responsibilities must be complemented by open and transparent modelling on national, population-based demand to inform local and regional recruitment needs.[132]

79. The Royal College of Physicians also supported better long-term workforce planning which it described as "crucial to the ability of the NHS to deliver better integrated care". It concluded that "greater transparency and accountability" was required than that offered by the Department's proposal.[133]

80. The Faculty of Sexual and Reproductive Healthcare and the Royal College of Obstetricians and Gynaecologists also agreed that greater transparency and accountability was necessary and argued that workforce data and planning should be published annually, with a legal duty placed on "a relevant body" (for example Health Education England) to undertake that work.[134] This was also the view of the Chartered Society of Physiotherapy, which called for "a national workforce strategy for the NHS and social care and clear transparent arrangements for reporting progress".[135]

128 White Paper, para 5.93
129 King's Fund (HSC001)
130 Q23
131 Q23
132 BMA (HSC0873)
133 The Royal College of Physicians (HSC0934)
134 The Faculty of Sexual and Reproductive Healthcare and The Royal College of Obstetricians and Gynaecologists (HSC0795)
135 The Chartered Society of Physiotherapy (HSC0927)

81. The Royal College of General Practitioners believed that a workforce report should include "five, ten, and 25-year horizons",[136] while the Royal College of Physicians argued for a "clear legal responsibility" to be placed on a designated body to publish workforce projections; and a corresponding duty to be placed on the Secretary of State to respond to those projections with a plan of action.[137] The Royal College of Nursing agreed, and set out what it believed the workforce projections report should cover:

- The projected health and care needs of the population, and workforce demand and supply, for the following 1–5 years, 5–10 years and 10–20 years.
- Workforce demand and supply trends for the previous 15 years
- Local, regional and national assessments and plans for service, workforce and finance planning, including workforce development requirements
- Any factors negatively affecting productivity
- Staffing levels and skill mix for safe and effective care
- Reducing inequalities within the workforce
- Existing UK Government obligations to adhere to ethical international recruitment practices.[138]

82. In supplementary evidence, the King's Fund, the Health Foundation and the Nuffield Trust set out in more detail, the form that annual workforce projections should take. They recommended that Bill:

a) Place a duty on Health Education England to publish annual, independently verified, projections of the future supply of the health care workforce in England and how those projections compare to projected demand for healthcare workforce in England for a 15 year period consistent with the long-term projections of health care spending produced by the Office for Budget Responsibility (OBR).

b) Place a duty on the Secretary of State for Health and Social Care to ensure that annual independently verified projections of the future supply of social care workforce in England are published, setting out how those projections compare to projected demand for social care workforce in England for a 15 year period, consistent with the long-term projections of adult social care spending produced by the OBR.

c) Require the publication of the assumptions underpinning the projections for the workforce flows from and to the other UK countries; and immigration and out-migration of the registered professions in health care. Those projections should be set out in headcount and full-time equivalent. At the England level, the projections should individually cover all the regulated professions (social workers, registered nurses, doctors, allied health professionals).

136 The Royal College of General Practitioners (HSC0950)
137 The Royal College of Physicians (HSC0934)
138 Royal College of Nursing (HSC0916)

d) Require the process for independent verification and a fixed annual date for publication to be published in advance.

e) Ensure that the Independent verification of the projections meet the relevant standards set out in the National Statistics Authority's code for official statistics for collecting, preparing, analysing and publishing government statistics.[139]

83. On 15 April 2021, the Academy of Medical Royal Colleges wrote to the Secretary of State on the matter of workforce projections. It argued that there was "a clear consensus of opinion" on the need for such projections and suggested that the Bill should include a statutory duty for:

- A regular published independent assessment of health and care workforce projections and requirements from a designated responsible body; and
- A requirement on Government to respond to that assessment.[140]

84. Sir Simon Stevens agreed that there was merit in the idea of an independent body publishing regular workforce projections, while Amanda Pritchard noted the financial cost to the Treasury of the "premium cost" of locum and agency staff to cover labour workforce shortages. She went on to say that:

> The ability to move to a much longer-term plan for the workforce, with much more surety around that and some safeguards around how it is then reported, feels eminently sensible.[141]

85. In his evidence to us the Secretary of State appeared sceptical of making such provisions in the Bill. He said that coming to a figure on the number of staff required was in itself a judgment, that there was "uncertainty over this question" and that "false objectivity" undermined good policy making.[142] He acknowledged that "endless bodies produce workforce forecasts" but argued that "to say that one particular independent expert has sole veracity and truth is false".[143] The Secretary of State set out his position on independent workforce projections in the following terms:

> Even if it may sound easy to say, "Let's have an independent target for this. Let's have some independent people set out the numbers on a spreadsheet," that does not make it any truer than the best judgment of a Minister.[144]

86. **We do not believe that the duty to publish an update on the roles and responsibilities once every five years is an adequate response to workforce shortages that are endemic in the NHS. We are very sympathetic to the detailed joint proposal from the Kings Fund, Health Foundation and Nuffield Trust to place a duty in the Bill to produce annual workforce projections. Equally, we welcome similar proposals submitted by the Academy of Medical Royal Colleges and Royal College of Nursing. The detail in**

139 Letter from the King's Fund, Health Foundation and the Nuffield Trust, 14 April 2021
140 Letter to the Secretary of State for Health and Social Care from the Academy of Medical Royal Colleges
141 Q121
142 Q160
143 Q162
144 Q161

**both proposals is key to ensuring that the Department and NHS England can develop strategies to adequately staff health and social care in the short, medium and longer term**

87. ***We therefore recommend that the Government include in the Bill, provisions to require Health Education England to publish objective, transparent and independent annual reports on workforce shortages and future staffing requirements that cover the next five, ten and twenty years including an assessment of whether sufficient numbers are being trained. We further recommend that such workforce projections cover social care as well as the NHS given the close links between the two systems. These reports should include input from staff, NHS bodies and unions, and content on the sufficiency of training should be reviewed by independent experts prior to publication.***

88. ***We further recommend that workforce reports be undertaken in consultation with the Devolved Administrations to ensure that a clear picture is given on the health and care workforce throughout the United Kingdom.***

# 6 Additional powers for the Secretary of State

## Introduction

89. The White Paper proposes a number of additional powers that would be conferred on the Secretary of State for Health and Social Care. These fall into three main areas which we consider specifically in turn later in this chapter:

- Powers of direction: for the Secretary of State to be granted powers to make structured interventions in relation to NHS England to set clear direction, support system accountability and agility, and also enable the Government to support NHS England to align its work effectively with wider priorities for health and social care.
- Reconfigurations: The White Paper proposes that the Secretary of State is given a power to intervene "at any point" in the reconfiguration process in relation to a Trust.
- Arm's Length Bodies: powers for the Secretary of State to transfer functions to and from specified Arm's Length Bodies, and where it is deemed necessary to the ability to abolish an Arm's Length Body.

90. In general, the White Paper does not set out in detail the range and restrictions that will accompany these powers and as a result, a number of our witnesses were concerned about the effect they could have on the day to day operational independence of the NHS.

91. The King's Fund argued that the direction of travel from primary to secondary legislation at the same time as powers were being moved from independent arm's length bodies to the Secretary of State required assurances that "an appropriate balance" would be struck between parliamentary oversight and reasonable flexibility for the health service.[145] Both the King's Fund and the Nuffield Trust argued that any additional powers required a commensurate level of parliamentary scrutiny and accountability to be put in place.[146] The NHS Confederation was of a similar view. It advised "caution" over proposals to increase the Secretary of State's powers of direction and advised that Ministers should "resist the temptation to centralise it further".[147]

92. A number of witnesses also believed that the new powers could result in the politicisation of decision-making in relation to the NHS. The Nuffield Trust said:

> Politicians face electoral incentives which are not aligned to the optimal running of a health service and previous Secretaries of State for Health from both parties have in the past revised the allocation formula for NHS funds in a political context.[148]

145 King's Fund (HSC001)
146 King's Fund (HSC001)
147 NHS Confederation (HSC0005)
148 Nuffield Trust (HSC0002)

93. The Health Foundation described the proposal to bring the NHS under closer ministerial control as "concerning" and warranted closer scrutiny. It warned that the proposals appeared to be "politically driven" and without a "clear rationale". To counter this, the Health Foundation asserted that the Government needed to:

> Clearly articulate the rationale and perceived benefits of the proposed changes, how additional powers will be used, and outline the checks and balances that will be in place to ensure that they are used as intended".[149]

94. In written evidence, the BMA stated that clear safeguards and limits would be necessary for all of the additional powers "to avoid increased political influence in NHS decision making and undermining long-term planning".[150] NHS Providers acknowledged that the White Paper offered reassurances that the Secretary of State "will not be involved in day-to-day operations". However, it warned that the clinical and operational independence of the NHS could be undermined by the "worrying trend within the proposals of the legislation allowing political overreach".[151]

95. In response to these concerns, the Secretary of State confirmed to us that "if and when a power of direction is exercised, it should be done transparently and subject to a public interest test".[152] The Secretary of State also confirmed that the clinical and operational independence of the NHS would be set out in legislation:

> That will be absolutely integral to the framing of the power of direction clauses in the Bill. The wording is slightly different from that which you have used a couple of times. It is clinical and day-to- day operational independence, and that will be enshrined in the approach that we take, which will be set out in primary legislation.[153]

96. **The Secretary of State for Health and Social Care is responsible to Parliament and the taxpayer for health and social care. It is therefore reasonable that the Secretary of State has the appropriate levers to ensure that Government policy is delivered. However, the White Paper does not give adequate detail on how the new powers proposed for the Secretary of State will be used. Nor does it set out the necessary safeguards to ensure that the powers do not open the door to the politicisation of the NHS.**

97. ***We recommend that the Bill includes provisions that set out in detail, both the range and restrictions that will apply to each of the additional powers proposed including provisions for transparency around ministerial interventions and the operation of the public interest test.***

## Direction to NHS England

98. The first proposal is for the Secretary of State to be granted powers to make structured interventions in relation to NHS England to set clear direction, support system accountability and agility, and also enable the Government to support NHS England to

149 Health Foundation (HC0004)
150 BMA (HSC0873)
151 NHS Providers (HSC0003)
152 Q142
153 Q143

align its work effectively with wider priorities for health and social care.[154] The White Paper states that these powers of intervention will be granted while maintaining the "clinical and day to day operational independence of the NHS".[155] As a reassurance, it continues that:

> These powers will not allow the Secretary of State to direct local NHS organisations directly nor will they allow the Secretary of State to intervene in individual clinical decisions.[156]

99. Despite that reassurance, contributors to our inquiry remained concerned by this power. The Patients Association thought that the proposal was defined "quite vaguely" and as a result, could amount to "a broad right for the Secretary of State override NHS England's decision-making, including for political reasons".[157] The NHS Confederation argued that the intention to give the Secretary of State more control over the direction of NHS England and NHS Improvement risked contradicting the ambition of the White Paper to facilitate integration and local leadership".[158]

100. If this power is to be conferred on the Secretary of State, our witnesses believed that additional safeguards needed to be put in place. For example, the Nuffield Trust argued that there should be a requirement to publish any direction or intervention and that any such direction laid before Parliament in the form of a draft Statutory Instrument so that Parliament could vote on its approval.[159]

101. In supplementary written evidence, NHS Providers said that the Bill needed to define this power in terms of:

- Its scope and the areas of decision making / activity where it might apply and, conversely, not apply;
- Full and timely transparency when the power is exercised, including a duty for the Secretary of State to set out why their use of the power of direction, on each occasion, meets an objectively defined public interest test; and
- Appropriate consultation with affected parties before the power is exercised including, as part of the transparency arrangements, the publication of the views of the body being directed.

Furthermore, NHS Providers believed that the Department should consult with the sector before these provisions are approved.[160]

102. ***We recommend that the Bill sets out in detail, the scope and areas of decision-making that will apply to this power. We further recommend that the Bill places a duty on the Secretary of State to publish any direction made by his office, including responses by the affected body, and that such powers are implemented in accordance with a public interest test.***

154 White Paper, para 3.18
155 White Paper, para 5.68
156 White Paper, para 5.71
157 The Patients Association (HSC0892)
158 NHS Confederation (HSC0005)
159 Nuffield Trust (HSC0002)
160 NHS Providers (HSC0987)

## Reconfiguration of services

103. The second power related to reconfigurations. At present, the Secretary of State is only able to intervene in a reconfiguration of services after receiving a local authority referral. Once received, the Secretary of State may commission the Independent Reconfiguration Panel to provide recommendations. After that, a final decision will be made. The White Paper proposes that the Secretary of State is given a power to intervene "at any point" in the reconfiguration process in relation to a Trust.[161]

104. The extension of the Secretary of State's power to intervene was highlighted by a number of organisations that submitted written evidence to our inquiry. The Royal College of General Practitioners said that it had "significant concerns" in relation to the proposed power, as the Royal College saw the potential for the powers to be "triggered in response to political pressures unrelated to the overarching needs of patients, the greater good for local health and care services, or contrary professional advice".[162] As a result it believed that detail was required on what independent advice would sought and considered, alongside strong safeguards to insure that "interventions in reconfigurations are for the greater good for patients and the service".[163] The Patients Association also argued in favour of the introduction of "well defined restrictions" on when it could be used, including a specific bar on the power being used to "overturn decisions which enjoy the strong, demonstrable support of affected and potentially affected patients".[164]

105. The British Medical Association captured the views of many organisations saying that:

> Increased powers to intervene in local service reconfigurations, whilst enabling reorganisations to occur earlier, could also leave the Secretary of State more vulnerable to pressure from local politicians to intervene in planned service reconfigurations. We would want to see clear safeguards and limits on the use of these powers included in any legislation.[165]

In a similar vein, the Royal College of Nursing believed that the proposal had the potential to "undermine local decision-making processes" and was "at odds with the direction of travel of the wider reforms" towards collaboration of local decision makers for the benefit of the local population.[166]

106. The King's Fund stated that reconfiguration decisions "should not be politicised" while the Nuffield Trust highlighted the risk that the power had the potential to create political incentives for the Secretary of State and for MPs that do not align with the best interests of people's health.[167]

107. The King's Fund acknowledged that while there may be exceptional cases that would require "escalation to a national level", decisions on such cases "should continue to be informed by the existing Independent Review Panel or a new independent panel." However, as the Nuffield Trust pointed out, the White Paper did not provide detail on any

161 White Paper, para 5.83
162 The Royal College of General Practitioners (HSC0950)
163 The Royal College of General Practitioners (HSC0950)
164 The Patients Association (HSC0892)
165 BMA (HSC0873)
166 Royal College of Nursing (HSC0916)
167 Nuffield Trust (HSC0002)

successor organisation to replace the Independent Reconfiguration Panel (IRP). In the absence of that, the Nuffield Trust believed that published criteria for intervention would be necessary so that any Ministerial intervention could be scrutinized effectively.[168]

108. When he came before us, Sir Simon Stevens explained that the principle of intervention had already been established and that "ultimately the Secretary of State gets to make the decision" in relation to reconfigurations. However, he believed that if the Secretary of State was to intervene earlier in the process that transparency would be important. He added that the use of any such powers of direction should be set out in writing and published at the time, "so that everybody can see what is going on". Furthermore, he believed that it would be subject to a public interest test so the use of the power of direction would be "justiciable".[169] Sir Simon also believed that Ministers would benefit from having expert clinical advice from "outwith the local area" in the form of the IRP or a successor body and told us that the IRP had "performed an important role in that respect in the past".[170]

109. NHS Providers told us that the following detail was required in relation to this power:

- That the Secretary of State's involvement in reconfigurations needed to be fully transparent, with the right of the affected parties to make appropriate representation; and the Secretary of State's intervention made against set, public, criteria;
- That a body like the Independent Reconfiguration Panel be retained to provide independent advice on detailed issues including the validity and importance of the clinical case for change
- That there should be an explicit test that use of the power must maintain or improve safety before the power can be exercised.[171]

110. **The Secretary of State already has the power to intervene in reconfigurations and therefore the proposal is an extension of that power in relation to the timing of an intervention. However, the White Paper is not clear on the criteria for intervention, nor is it clear on the role or replacement of the Independent Review Panel. This lack of clarity needs to be addressed if there is to be confidence in the process of Ministerial intervention in reconfigurations.**

111. ***We recommend that provisions be included in the Bill that set out the criteria under which the Secretary of State may intervene in reconfigurations. We further recommend that a duty be placed on the Secretary of State to lay before Parliament all information and advice in relation to an intervention in a reconfiguration.***

## Functions of arm's length bodies

112. The third power proposed for the Secretary of State is the ability to transfer functions to and from specified Arm's Length Bodies, and, where it is deemed necessary to, the ability to abolish an Arm's Length Body (ALB).[172]

168 Nuffield Trust (HSC0002)
169 Q125
170 Q126
171 NHS Providers (HSC0987)
172 White Paper, Annex A

113. NHS Providers argued that this new power represented "a further significant centralisation of power and potential loss of independence for the NHS from political considerations".[173] The Royal College of Physicians welcomed the Department's assurance that it would undertake a consultation on any proposals for transfer of functions between arms-length bodies. However, it argued that in doing so, the Department must "meaningfully" engage with stakeholders, including the affected ALB and that their views on any proposed transfer of functions must be heard.[174]

114. The King's Fund did not support this additional power without the need for primary legislation. It argued that it was "hard to justify giving the Secretary of State powers that are not currently needed just in case they may be in the future" as the new powers could "erode the autonomy of arm's length bodies". If such powers are to be granted, the King's Fund believed that "arrangements for review and accountability after use of the powers [and] arrangements for consultation before their use" should be included on the face of the Bill.[175] The Nuffield Trust also put forward the view that the power would "enable a future government to carry out reorganisation on a scale usually done in the NHS through primary legislation". It believed that if such changes were to be made by secondary legislation it should be made under the affirmative procedure to enable scrutiny and debate by MPs.[176]

115. NHS Providers also recognised the "logic" of the Secretary of State having the power to move responsibilities between Arm's Length Bodies by secondary legislation. However, it believed that it would be "inappropriate" for those powers to be used either to abolish the newly merged NHS England or the Care Quality Commission, or to "neuter" those bodies by transferring the majority of their powers to other bodies.[177]

116. **The additional powers proposed for the Secretary of State have the potential to provide a more agile response to the changing health and care landscape. However, that power requires a commensurate level of Ministerial accountability and Parliamentary scrutiny. We believe that the Bill should set out in detail the extent of this power and the restrictions on its use - including bodies that would be outwith the scope of the power—so that it does not become an unfettered power to chop and change the ability of arms' length bodies to carry out their important roles.**

117. ***We recommend that the Bill includes schedules setting out the use and restrictions of the power to transfer responsibilities of Arm's Length Bodies -including a list of bodies outwith the scope of the power. We further recommend that the affirmative procedure for secondary legislation is used in the transfer of functions and responsibilities of Arm's Length Bodies to ensure that Parliament has the ability to approve or reject such changes.***

173 NHS Providers (HSC0003)
174 The Royal College of Physicians (HSC0934)
175 King's Fund (HSC001)
176 Nuffield Trust (HSC0002)
177 NHS Providers (HSC0987)

# 7 Public health

118. The White Paper states that the Government will "in due course" publish an update on proposals for the future design of the public health system, including the establishment of the new National Institute for Health Protection.[178] This will include legislative measures to:

- Make it easier to secure rapid change updates in NHS England's public health functions including powers to restrict the advertising of high fat, salt and sugar foods.
- The introduction of a new power for Ministers to alter food labelling requirements.
- The return of responsibility for the fluoridation of water in England from local authorities to central Government.[179]

119. The White Paper stated that:

> Local government delivery is also rooted in firm foundations: in serving its residents, with strong local democratic accountability, and expertise in the health, public health and care needs of its populations. To protect these principles, which are so close to all our hearts, we must back those who make them a reality every day of their lives—by building and constantly renewing a culture of collaboration.[180]

## Obesity

120. The UK Faculty of Public Health welcomed the measures in relation to obesity,[181] while the Association of Directors of Public Health agreed with proposals for further restrictions being placed on the advertising of products high in fat, sugar and salt, and better food labelling requirements.[182] The Local Government Association was also in favour of the proposals, but cautioned that local authorities needed to be "an equal partner" in the design this work and that it needed to "build on existing sector led improvement work".[183]

121. Nigel Edwards from the Nuffield Trust agreed that there was "a very clear role" for local government in the development of the proposals for public health,[184] while Richard Murray recognised the potential "tension" between consistency around governance and accountability while retaining some of the local flexibility".[185]

## Mental health and Wellbeing

122. Richard Murray, King's Fund believed that the reforms also had the potential for mental health and wellbeing "to be focused on at a population level". However, he saw a risk that this could "fall by the wayside" should the focus of the NHS and the ICSs be

178 White Paper, Executive summary
179 White Paper, Executive summary
180 White Paper, Forward
181 UK Faculty of Public Health (HSC0026)
182 Association of Directors of Public Health (HSC0902)
183 Local Government Association (HSC0011)
184 Q8
185 Q9

on reducing waiting times.[186] Carers UK also highlighted wellbeing and argued that a specific duty be placed on the NHS to have regard to carers and to promote their health and wellbeing.[187] National Voices also wanted to see "much clearer commitments" to strengthening health and wellbeing and health inequality throughout all areas of local and national policy and spending and believed that the Bill presented "an opportunity to make this real".[188]

123. When we he came before us, the Secretary of State said that ICSs "absolutely will have a duty to look out for people's mental as well as physical health" and that placing that duty on the face of the Bill would be something to be debated during the passage of the Bill through Parliament.[189]

## Fluoridation

124. We received contrasting views in written submissions in relation to the proposals on fluoridation. Both the British Dental Association and the Association of Directors of Public Health welcomed the proposal,[190] while the Association of Dental Groups described a national programme for water fluoridation as "the single biggest preventative measure that could be taken to protect the nation's oral health in the future".[191]

125. That said, a number of submissions recognised that any national programme would need careful handling. The UK Faculty for Public Health broadly supported the proposal but argued that it "must not be imposed on communities without their consent" and should only be introduced after public consultation.[192] This view was echoed by the Local Government Association who argued that water fluoridation "must not be imposed on communities" and that local decision-makers were "best placed to take into account locally-expressed views and to balance the perceived benefits of fluoridation with the ethical arguments and any evidence of risks to health".[193]

126. We also received submissions from organisations and individuals[194] opposed to water fluoridation. The UK Freedom From Fluoride Alliance set out its opposition to the fluoridation of water but stated that should it continue, "the issue should remain in the hands of the Local Authorities in whose area a new proposal arises".[195] This position was supported by Hampshire Against Fluoridation which believed that any decisions had to be decided by local elected representatives "who know the local situation and are directly responsible to the people in the area".[196] Bromsgrove for Pure Water also described the proposal as "ill-considered".[197]

186 Q10
187 Carers UK (HSC0942)
188 National Voices (HSC0979)
189 Q150
190 Association of Directors of Public Health (HSC0902)
191 Association of Dental Groups (HSC0024)
192 UK Faculty of Public Health (HSC0026)
193 Local Government Association (HSC0011)
194 Mrs Cynthia Bagchi (HSC0022), Fluoride Free Cumbria (HSC0032), Denise Dell (HSC0848), Douglas Cross (HSC0896), George Pinnell (HSC0918), Dr Andrew Dowell (HSC0976) David William Forrest (HSC0019)
195 The United Kingdom Freedom From Fluoride Alliance (HSC0010)
196 John Spottiswoode, Chairman of Hampshire Against Fluoridation (HAF) (HSC0015)
197 Bromsgrove for Pure Water (HSC0020)

127. **We are broadly supportive of the proposals in the White Paper on public health although did not consider them in detail. Therefore, we do not make detailed recommendations on the potential merits of the individual proposals. However, we conclude that there are wider health benefits to including in the Bill a duty to be placed on ICSs to have specific regard to public health, mental health and well-being and the prevention of ill-health.**

128. ***We recommend that the Bill include provisions to place a core duty on ICSs to have regard to public health and mental health; and to include in ICSs' public health duties, a requirement to develop strategies to ensure the prevention of ill-health through the delivery of programmes to support the wellbeing of the local community, health and care staff and voluntary organisations that support the health and care sector.***

129. **We welcome the direction of travel in the White Paper's proposals to tackle obesity. If this is to be successful, the proposals on food advertising should reflect the fact that the viewing habits of children and young people are not restricted to television but extend to social media and online providers of content.**

130. **We did not consider the fluoridation proposals during our evidence session. That said, it was covered by a number of submissions from both individuals and organisations that were opposed to the proposal and several clinical bodies that were in favour of it; and we draw the Department's attention to that evidence. The Secretary of State will recognise the long-standing debate on fluoridation, and we look to him to set out a balanced response to both sides of the argument during the debates on the Bill.**

# 8 Reducing bureaucracy

## The Government's proposals

131. The Executive Summary of the White Paper set out the Department's proposals to amend the Health and Social Care Act 2012 in relation to procurement and the delivery of healthcare services to better reflect the needs of individual ICSs.[198] The ambition is to legislate to reduce the bureaucracy that inhibits flexibility and integration and to streamline accountability.[199] The proposals include:

- Enabling the NHS to make decisions on how it organises itself without the involvement of the Competition and Markets Authority (CMA).
- The creation of a bespoke health services provider selection regime.
- Changes to the NHS tariff to enable it to work more flexibly.[200]

132. The Proposals would also:

- Replace the Competition and Markets Authority with NHS England as the reviewing body of mergers involving foundation Trusts.
- Remove NHS Improvement's specific competition functions and its general duty to prevent anti-competitive behaviour.
- Remove the requirement for NHS England to refer contested licence conditions or National Tariff provisions to the CMA.[201]

## Changes to procurement and commissioning

133. Commissioners will be given more discretion over when to use procurement process to arrange services, with proportionate checks and balances;[202] the commissioning of healthcare services will be removed from the scope of the Public Contracts Regulations 2015 and Section 75 of the Health and Social Care Act 2012; and the Procurement, Patient Choice and Competition Regulations 2013 will be repealed.[203]

134. The Academy of Medical Royal Colleges supported removing the jurisdiction of the Competition and Markets Authority and the decision to repeal Section 75 of the Health and Social Care Act 2012.[204] The BMA were of a similar view. It stated that that Section 75 regime had resulted in costly procurement processes, increased fragmentation of care and has destabilised NHS services.[205] It also stated that the provisions of Section 75 had resulted in:

198 White Paper, Executive summary
199 White Paper, para 3.13
200 White Paper, para 3.15
201 White Paper, paras 5.42–43
202 White Paper, para 5.46
203 White Paper, para 5.47
204 Academy of Medical Royal Colleges (HSC0782)
205 BMA (HSC0873)

> Private sector companies cherry picking some of the NHS's most profitable contracts, as well as successfully "suing" the NHS for anti-competitive awarding of contracts or behaviour at a significant cost to the NHS.[206]

135. UNISON also welcomed the proposal. It believed that this would result in commissioners no longer operating under a "default assumption of using competition to arrange services" and therefore would have a greater level of discretion in commissioning.[207] In addition, the Royal College of General Practitioners stated that the Section 75 powers had "acted as a significant barrier to the development of new care models and collaboration between NHS providers over the last decade".[208]

136. The Academy of Medical Royal Colleges also supported the proposal to remove the jurisdiction of the Competition and Markets Authority,[209] as did Unison who described this as a "move away from the current adversarial system".[210] The Royal College of Physicians also welcomed the proposal to repeal the competition role of the Competition and Markets Authority.[211]

137. However, the BMA argued that the Bill should include provisions to establish the NHS as the preferred provider of services to protect the NHS from instability and prevent further privatisation. The BMA also highlighted the importance of adequate provisions in the Bill to facilitate sufficient scrutiny and transparency over the tendering and awarding of contracts.[212] However, it cautioned that any new financial arrangements must work to enable and support collaboration and integration and do not act as a barrier.[213]

138. The Nuffield Trust broadly welcomed the proposed reforms to procurement, as did NHS Providers, who believed that the proposals to move away from "competitive retendering and burdensome procurement processes" was a positive step.[214] However, the Nuffield Trust highlighted the risk of the proposals establishing "an overly cosy approach that favours incumbents and excludes innovators".[215] Therefore, it stated that clear and transparent criteria were required for commissioners to test whether an existing provider was doing a "sufficiently good job." In a similar vein, the Nuffield Trust noted that "elective services which rely on cross-specialty working" that meet the threshold for renewal: could cover "a very broad range of services".[216] To counter this, the Nuffield Trust suggested the introduction of "formal and particular monitoring of the proportion of contracts which change from year to year".[217]

206 BMA (HSC0873)
207 UNISON (HSC0886)
208 The Royal College of General Practitioners (HSC0950)
209 Academy of Medical Royal Colleges (HSC0782)
210 UNISON (HSC0886)
211 The Royal College of Physicians (HSC0934)
212 BMA (HSC0873)
213 Academy of Medical Royal Colleges (HSC0782)
214 NHS Providers (HSC0003)
215 Nuffield Trust (HSC0002)
216 Nuffield Trust (HSC0002)
217 Nuffield Trust (HSC0002)

139. The King's Fund noted that healthcare in England "has never been a truly competitive market" and that the evidence for the benefits of competition was at best "equivocal".[218] However, it saw a need to include in the Bill, provisions to mitigate the risk that new contracts were "automatically handed out to incumbent providers", and to facilitate "a diversity of provision from voluntary sector, social enterprise, and NHS organisations".[219]

140. When he gave evidence to us, Sir Simon Stevens said that the changes to the procurement regime "would free up a lot of time and wasted effort from some of the transactional purchasing arrangements, which tend to reinforce the fragmentation of care that we have otherwise seen". He believed that formalising those changes would ensure that they were both transparent and accountable.[220]

141. Sir Simon Stevens further told us that the combined effect of the Section 75 regime and public contract regulations 2015 had resulted in the need to run competitive tendering processes that led to "some pretty spurious processes". As examples, he cited competition requirements for specialist cancer services and cardiovascular tertiary services when the reality was that there were no competitors that could replace the Royal Marsden or Guy's and St Thomas' or Central Manchester foundation trust. In his opinion, that aspect of procurement was little more than "spurious activity".[221]

142. Amanda Pritchard also told us that the proposed legislation would make it "easier to avoid having to go through multiple competitive tenders" where "people have gone for very short term, very inflexible contracts that have had to be relet almost year on year". She described the benefits of the proposals as the ability to "allow a different process that does not require the same sort of formalised procurement arrangement". However, she stressed that there would be "a proper framework in place, not just to roll things over without due process around looking at value for money, quality and patient feedback and, clearly, an expectation of continuous improvement".[222]

143. Amanda Pritchard also told us that a key role for ICSs in this would be to share "good practice and innovation". She added that while this hadn't been discussed in relation to legislation, it was something that NHS England was considering issuing guidance on in relation to "the role of ICSs, the role of regions more generally, and our whole approach as we think about planning guidance for the next year".[223]

144. **We welcome the proposals to reduce bureaucracy in NHS procurement, which have been broadly well received by stakeholders. If they are implemented in a clear and transparent way, they have the potential to both streamline Trusts' procurement practices and reduce their financial and administrative burdens. That said, a framework of clear guidance and monitoring will need to be put in place to ensure that a lighter touch regime does not inadvertently establish practices that favour incumbents and excludes innovators. We note that implementation of the Health and Social Care Act 2012 led to unintended consequences in terms of bureaucracy and procurement and therefore for this set of changes it is extremely important to make sure implementation is well executed.**

218 King's Fund (HSC001)
219 King's Fund (HSC001)
220 Q85
221 Q96
222 Q98
223 Q98

145. ***We recommend that alongside the proposals to remove competition regulation, the Department establishes a framework that formally monitors and makes public annually:***

a) ***the proportion of contracts which change from year to year and the companies that were awarded contracts or had contracts renewed in each year ;***

b) ***the proportion of contracts awarded to small and medium-sized enterprises;***

c) ***value for money of those contracts; and***

d) ***the patient experience.***

***That framework should also ensure that innovation and diversity of provision from voluntary sector, social enterprise, and NHS organisations is encouraged and supported***

146. ***Because of the importance of implementation, the Committee puts the Government on notice that we will return to these issues before the end of the Parliament in time to assess how effectively the plans have been put in place. We will also ask the Secretary of State, NHS representatives and patient groups to return to the Committee on a regular basis to brief us on progress in implementation.***

# Conclusions and recommendations

## The White Paper

1. We support the proposals in the White Paper that will be included in the new Bill and welcome the direction of travel in the Government's reform of health and social care. Provided that proper accountability mechanisms are put in place, particularly relating to the safety and quality of care, we believe that creation of Integrated Care Systems throughout England has the potential to improve the delivery of care services for patients. However, there are areas in the White Paper that require further clarity or revision—and some concerning omissions which we set out in the subsequent chapters of this Report. (Paragraph 13)

2. We welcome the Secretary of State's confirmation that the statutory right of a patient to choose where they receive treatment will be retained in the forthcoming legislation. We welcome the Secretary of State's commitment to this and look forward to seeing provisions in the Bill to maintain and enhance patient outcomes and to retain the patient's right to receive treatment outside the area served by their local ICS. (Paragraph 19)

3. We welcome the Secretary of State's commitment to include in the Bill, at our suggestion, provisions to enable the Care Quality Commission to undertake ratings of Integrated Care Systems. As an independent regulator it must for the CQC to decide how such inspections and ratings work but we note that the success of the system to date has been partly because the core domains (safe, effective, caring, responsiveness and governance) are largely patient-facing, so it is essential such an approach is maintained including a domain that focuses on safety and quality and is named as such. We believe within these domains it should be possible to include assessment of delivery of core NHS England and DHSC objectives so that there is alignment of objectives across the system. (Paragraph 24)

4. *We recommend that the CQC's assessment of ICSs includes consultation with patient groups and consideration of patient outcomes, and that all relevant data is published.* (Paragraph 25)

5. *We further recommend that the CQC rating includes progress ICSs make on the integration of information technology between primary care, secondary care and the social care sector.* (Paragraph 26)

6. While we accept the importance of the timely implementation of the proposed Bill, we recognise the concerns raised by our witnesses about the effect this may have on the NHS and the care sector; both of which have been put under unprecedented strain during the covid-19 pandemic. The Government must be alive to the need for flexibility in the timetable for implementation as the scale of the post-pandemic backlog becomes clearer. (Paragraph 30)

7. *Different parts of England will be further along the journey towards integration than others. In order for all areas to benefit from Integrated Care Systems, we recommend that*:

a) *The Department and NHS England ensure that processes are in place to share best practice quickly and effectively so that all areas can implement these reforms efficiently, with additional practical support mechanisms offered to ICSs that get low CQC ratings*;

b) *The implementation period takes into account fully, the fact that parts of the country will be at different starting points on this journey; and*

c) *Local NHS leaders have a role in setting the pace of the implementation to ensure that the establishment of ICSs will not adversely impact an area's covid-19 response or recovery.* (Paragraph 31)

## Integrated Care Systems

8. The success of ICSs will, in no small part, be dependent on good working relations between the NHS Body and Health and Care Partnership. While we agree with Sir Simon Stevens that the proposals provide flexibility for local decision-making, clear lines of accountability will be necessary to ensure that both component parts of an ICS can function efficiently and effectively. (Paragraph 45)

9. *We therefore recommend that the Government include in the Bill a more detailed framework that sets out the roles and responsibilities of both the NHS Body and the Health and Care Partnership and of the Chair of the ICS. NHS England should set out in guidance how the responsibilities and accountabilities of NHS trusts and foundation trusts align with these to avoid confusion, duplication or overlap.* (Paragraph 46)

10. It is vital that local populations have confidence in the boards of the NHS Body and the Health and Care Partnership and transparency in the appointment process for those boards will be a key factor in that. If NHS Bodies and Health and Care Partnerships are to be successful they must not be dominated by the views of the NHS but draw on the experience and expertise in all areas of the health and care sectors as equal partners. *We therefore recommend that a duty be placed on ICS boards to ensure that*:

d) *the composition of boards includes representatives with experience and expertise in the views and needs of patients, carers and the social care sector.*

e) *where an ICS's decision-making affects carers and the social care sector, that the ICS undertake formal consultation with the groups and sectors affected.* (Paragraph 52)

11. The White Paper will give the Secretary of State the ultimate responsibility for appointments to NHS boards. Given the concerns about the potential politicisation of the NHS, there will need to be full transparency in the appointment process. *We therefore recommend that the Bill sets out the criteria by which the Secretary of State will use this power so that appointments and vetoes decided upon can be assessed.* (Paragraph 53)

12. We conclude that the Bill provides a timely vehicle to introduce reforms to the fit-and-proper persons test for appointments to NHS boards. *We therefore recommend that the Bill is used to establish a UK-wide public register of people that are holding,*

*have held, or are seeking to hold a position on an NHS board. We also recommend that NHS England and the Department undertake a review of the adequacy of the training and support provided to board members.* (Paragraph 54)

## Proposals for Social care

13. We were concerned that the White Paper did not set out a long-term plan for social care. The absence of a fully funded plan for social care has the potential to destabilise Integrated Care Systems and undermine their success. However, we note that the Prime Minister has committed the Government to producing a 10-year plan later this year; and we would be extremely disappointed if detailed plans for this were not published before the end of the calendar year. It is vital that this plan is fully costed and funded at the levels set out in our Report, Social care: funding and workforce. Without secure, long-term funding, the problems that have bedevilled the care sector over the last two decades will not be solved. (Paragraph 64)

14. *The social care sector needs reassurance that both the structural and financial problems it faces will be tackled by the Government in a timely way. For that reason, we recommend that a duty is included in the Bill for the Secretary of State to publish a 10-year plan with detailed costings within six months of the Bill receiving Royal Assent.* (Paragraph 65)

15. *Unpaid carers are partners in care and it is deeply concerning that the White Paper does not mention unpaid family carers at all. We welcome the commitment by the Secretary of State to consider what support and representation can be given to unpaid carers, and recommend that the NHS should have a responsibility to have regard to carers and to promote their health and wellbeing. This should be included in the Bill. We further recommend that provisions to protect carers' rights on discharge also be included in the Bill.* (Paragraph 66)

16. The involvement of the CQC in Ofsted-style rating of social care provision by local authority area would create parity in accountability with the new ICSs and shine a much-needed light on local variation in the provision of social care. However, for this to be successful the social care system needs to have in place a fully funded 10-year plan to sit alongside the NHS's own 10-year plan. (Paragraph 72)

17. *We recommend that, following consultation with local government on its implementation, the Bill gives the CQC powers to give Ofsted-style ratings for local authority social care.* (Paragraph 73)

18. *We further recommend that the CQC ratings includes consideration of food standards in social care settings to better align social care and the NHS in relation to the proposals in the White Paper on food and nutrition standards in the NHS.* (Paragraph 74)

19. *We recommend that the new Bill gives the CQC powers to give Ofsted-style ratings for local authority social care provision but that these are not enacted until the 10 year social care plan is published later this year and there has been full consultation with local government.* (Paragraph 75)

## Workforce

20. We do not believe that the duty to publish an update on the roles and responsibilities once every five years is an adequate response to workforce shortages that are endemic in the NHS. We are very sympathetic to the detailed joint proposal from the Kings Fund, Health Foundation and Nuffield Trust to place a duty in the Bill to produce annual workforce projections. Equally, we welcome similar proposals submitted by the Academy of Medical Royal Colleges and Royal College of Nursing. The detail in both proposals is key to ensuring that the Department and NHS England can develop strategies to adequately staff health and social care in the short, medium and longer term (Paragraph 86)

21. *We therefore recommend that the Government include in the Bill, provisions to require Health Education England to publish objective, transparent and independent annual reports on workforce shortages and future staffing requirements that cover the next five, ten and twenty years including an assessment of whether sufficient numbers are being trained. We further recommend that such workforce projections cover social care as well as the NHS given the close links between the two systems. These reports should include input from staff, NHS bodies and unions, and content on the sufficiency of training should be reviewed by independent experts prior to publication.* (Paragraph 87)

22. *We further recommend that workforce reports be undertaken in consultation with the Devolved Administrations to ensure that a clear picture is given on the health and care workforce throughout the United Kingdom.* (Paragraph 88)

## Additional powers for the Secretary of State

23. The Secretary of State for Health and Social Care is responsible to Parliament and the taxpayer for health and social care. It is therefore reasonable that the Secretary of State has the appropriate levers to ensure that Government policy is delivered. However, the White Paper does not give adequate detail on how the new powers proposed for the Secretary of State will be used. Nor does it set out the necessary safeguards to ensure that the powers do not open the door to the politicisation of the NHS. (Paragraph 96)

24. *We recommend that the Bill includes provisions that set out in detail, both the range and restrictions that will apply to each of the additional powers proposed including provisions for transparency around ministerial interventions and the operation of the public interest test.* (Paragraph 97)

25. *We recommend that the Bill sets out in detail, the scope and areas of decision-making that will apply to this power. We further recommend that the Bill places a duty on the Secretary of State to publish any direction made by his office, including responses by the affected body, and that such powers are implemented in accordance with a public interest test.* (Paragraph 102)

26. The Secretary of State already has the power to intervene in reconfigurations and therefore the proposal is an extension of that power in relation to the timing of an intervention. However, the White Paper is not clear on the criteria for intervention,

nor is it clear on the role or replacement of the Independent Review Panel. This lack of clarity needs to be addressed if there is to be confidence in the process of Ministerial intervention in reconfigurations. (Paragraph 110)

27. *We recommend that provisions be included in the Bill that set out the criteria under which the Secretary of State may intervene in reconfigurations. We further recommend that a duty be placed on the Secretary of State to lay before Parliament all information and advice in relation to an intervention in a reconfiguration*. (Paragraph 111)

28. The additional powers proposed for the Secretary of State have the potential to provide a more agile response to the changing health and care landscape. However, that power requires a commensurate level of Ministerial accountability and Parliamentary scrutiny. We believe that the Bill should set out in detail the extent of this power and the restrictions on its use - including bodies that would be outwith the scope of the power—so that it does not become an unfettered power to chop and change the ability of arms' length bodies to carry out their important roles. (Paragraph 116)

29. *We recommend that the Bill includes schedules setting out the use and restrictions of the power to transfer responsibilities of Arm's Length Bodies -including a list of bodies outwith the scope of the power. We further recommend that the affirmative procedure for secondary legislation is used in the transfer of functions and responsibilities of Arm's Length Bodies to ensure that Parliament has the ability to approve or reject such changes*. (Paragraph 117)

## Public health

30. We are broadly supportive of the proposals in the White Paper on public health although did not consider them in detail. Therefore, we do not make detailed recommendations on the potential merits of the individual proposals. However, we conclude that there are wider health benefits to including in the Bill a duty to be placed on ICSs to have specific regard to public health, mental health and well-being and the prevention of ill-health. (Paragraph 127)

31. *We recommend that the Bill include provisions to place a core duty on ICSs to have regard to public health and mental health; and to include in ICSs' public health duties, a requirement to develop strategies to ensure the prevention of ill-health through the delivery of programmes to support the wellbeing of the local community, health and care staff and voluntary organisations that support the health and care sector.* (Paragraph 128)

32. We welcome the direction of travel in the White Paper's proposals to tackle obesity. If this is to be successful, the proposals on food advertising should reflect the fact that the viewing habits of children and young people are not restricted to television but extend to social media and online providers of content. (Paragraph 129)

33. We did not consider the fluoridation proposals during our evidence session. That said, it was covered by a number of submissions from both individuals and organisations that were opposed to the proposal and several clinical bodies that were in favour of it; and we draw the Department's attention to that evidence. The

Secretary of State will recognise the long-standing debate on fluoridation, and we look to him to set out a balanced response to both sides of the argument during the debates on the Bill. (Paragraph 130)

## Reducing bureaucracy

34. We welcome the proposals to reduce bureaucracy in NHS procurement, which have been broadly well received by stakeholders. If they are implemented in a clear and transparent way, they have the potential to both streamline Trusts' procurement practices and reduce their financial and administrative burdens. That said, a framework of clear guidance and monitoring will need to be put in place to ensure that a lighter touch regime does not inadvertently establish practices that favour incumbents and excludes innovators. We note that implementation of the Health and Social Care Act 2012 led to unintended consequences in terms of bureaucracy and procurement and therefore for this set of changes it is extremely important to make sure implementation is well executed. (Paragraph 144)

35. *We recommend that alongside the proposals to remove competition regulation, the Department establishes a framework that formally monitors and makes public annually*:

    f) *the proportion of contracts which change from year to year and the companies that were awarded contracts or had contracts renewed in each year*;

    g) *the proportion of contracts awarded to small and medium-sized enterprises*;

    h) *value for money of those contracts; and*

    i) *the patient experience.*

    *That framework should also ensure that innovation and diversity of provision from voluntary sector, social enterprise, and NHS organisations is encouraged and supported.* (Paragraph 145)

36. *Because of the importance of implementation, the Committee puts the Government on notice that we will return to these issues before the end of the Parliament in time to assess how effectively the plans have been put in place. We will also ask the Secretary of State, NHS representatives and patient groups to return to the Committee on a regular basis to brief us on progress in implementation.* (Paragraph 146)

# Formal minutes

## Tuesday 11 May 2021

Members present:

Jeremy Hunt, in the Chair

| | |
|---|---|
| Paul Bristow | Taiwo Owatemi |
| Rosie Cooper | Sarah Owen |
| Dr James Davies | Dean Russell |
| Dr Luke Evans | Laura Trott |
| Barbara Keeley | |

Draft Report (*The Government's White Paper proposals for the reform of Health and Social Care*), proposed by the Chair, brought up and read.

*Ordered*, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 146 read and agreed to.

*Resolved*, That the Report be the First Report of the Committee to the House.

*Ordered*, That the Chair make the Report to the House.

*Ordered*, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Tuesday 18 May at 9.00am

# Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

### Tuesday 02 March 2021

**Richard Murray**, Chief Executive, The King's Fund; **Hugh Alderwick**, Head of Policy, The Health Foundation; **Nigel Edwards**, Chief Executive, The Nuffield Trust Q1–30

**Danny Mortimer**, Chief Executive, NHS Confederation; **Sarah Pickup**, Deputy Chief Executive, Local Government Association; **Sir Robert Francis**, Chair, HealthWatch England; **Chris Hopson**, Chief Executive, NHS Providers Q31–64

### Tuesday 09 March 2021

**Sir Simon Stevens**, Chief Executive, NHS England and NHS Improvement; **Amanda Pritchard**, Chief Operating Officer, NHS England and NHS Improvement Q65–130

### Tuesday 16 March 2021

**Rt Hon Matt Hancock**, Secretary of State, Department of Health and Social Care; **Jason Yiannikkou**, Director of NHS Legislation Programme, Department of Health and Social Care Q131–195

# Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

HSC numbers are generated by the evidence processing system and so may not be complete.

1 AYMES (HSC0860)

2 Academy of Medical Royal Colleges (HSC0782)

3 Academy of Medical Sciences (HSC0940)

4 Action on Salt and Action on Sugar (HSC0724)

5 Adam Smith Institute (HSC0025)

6 Advanced Accelerator Applications (HSC0030)

7 Advisory Group on Contraception (HSC0898)

8 Against, Chairman of Hampshire (HSC0015)

9 Age UK (HSC0986)

10 Alliance, Specialised Healthcare (Secretariat, Specialised Healthcare Alliance) (HSC0881)

11 Allied Health Professions Federation (AHPF) (HSC0774)

12 Alzheimer's Society (HSC0959)

13 Anthony Nolan (HSC0768)

14 Association of Dental Groups (HSC0024)

15 BMA (British Medical Association) (HSC0873)

16 BUPA (HSC0885)

17 Bainbridge, Mr David (HSC0491)

18 Bagchi, Mrs Cynthia (HSC0022)

19 Bajina, Mr John (Manager, Bajinc Ltd) (HSC0210)

20 Baksi, Dr Sonya (Retired consultant community paediatrician, retired member British Medical Association) (HSC0606)

21 Bannerman, Stuart (Retired) (HSC0215)

22 Bisgrove, Mr Gareth (Emergency Ambulance Crew, London Ambulance Service NHS Trust) (HSC0614)

23 Blackman, Dr Roger (HSC0811)

24 Boote, Sarah (HSC0536)

25 Boothroyd, Christopher (HSC0007)

26 British Association for Sexual Health and HIV (BASHH) (HSC0937)

27 British Dental Association (HSC0955)

28 British HIV Association (HSC0862)

29 British HIV Association (HSC0908)

30 British International Doctors Association (HSC0872)

31 British Red Cross (HSC0965)

32 British Specialist Nutrition Association (HSC0920)

33 Bromsgrove for Pure Water (HSC0020)

34 Brookes, Dr Sasha (HSC0560)

35 Browne, Professor Kevin (Director of Centre for Forensic and Family Psychology, School of Medicine, University of Nottingham) (HSC0008)

36 Bupa Dental Care (HSC0926)

37 Campaign for Freedom of Information (HSC0980)

38 Camurus (HSC0983)

39 Cancer Research UK (HSC0889)

40 Care England (HSC0783)

41 Care Quality Commission (HSC0906)

42 Carers Trust (HSC0028)

43 Carers UK (HSC0942)

44 Carnaghan, Mr Robert (HSC0928)

45 Centre for Mental Health (HSC0954)

46 Chamings, Mr Andrew (Retired teacher, Brayton College) (HSC0634)

47 Chartered Society of Physiotherapy (HSC0927)

48 Christian Science Committee on Publication (HSC0839)

49 City & Guilds (HSC0903)

50 Clein, Mr Paul (Pharmacist, Self employed) (HSC0658)

51 Coproduce Care CIC (HSC0806)

52 Cross, Mr Douglas (Forensic Ecologist, FRSB, UK Councils Against Fluoridation) (HSC0896)

53 Dale, Ms Eileen (HSC0635)

54 Davis, Mr Richard (Electronic Engineer and Company Director, Reynard Electronics Ltd) (HSC0127)

55 Dell, Mrs Denise (HSC0848)

56 Diabetes UK (HSC0923)

57 Dignan, Mrs Mary (HSC0340)

58 Dignity in Dying (HSC0808)

59 Doctors for the NHS (HSC0968)

60 Donovan, Liz (Retired Nurse) (HSC0656)

61 Dowell, Dr Andrew (Retired, Warwick University) (HSC0976)

62 Dowse, Ms Wendy M (HSC0621)

63 Edwards Lifesciences (HSC0858)

64 Ehrlicher, Steve (HSC0282)

65 Endometriosis UK (HSC0930)

66 FODO - Association of Eye Care Providers; and NCHA - National Community Hearing Association (HSC0925)

67 Forrest, Mr David William (HSC0019)

68 Faculty of Sexual and Reproductive Healthcare (FSRH); and Royal College of Obstetricians and Gynaecologists (RCOG) (HSC0795)

69 Floyd, Mr James (Public Affairs Officer, Anchor Hanover) (HSC0027)

70 Fluoride Free Cumbria (HSC0032)

71 Fraser, Mr Don (Retired, Policeman) (HSC0341)

72 Good Things Foundation (HSC0900)

73 Guy, Dr Mary (HSC0785)

74 Hall, Dr Nicola (HSC0392)

75 Hammersmith and Fulham Save Our NHS (HAFSON) (HSC0893)

76 Harniman, Mr Gerald (Retired FE College Senior Lecturer, Westminster College of Further Education (now Westminster & Kingsway College)) (HSC0371)

77 Harrowing, Karen (HSC0946)

78 Health Foundation (HSC0004)

79 HealthWatch England (HSC0006)

80 Healthcare Financial Management Association (HSC0859)

81 Hologic (HSC0794)

82 Horler, Wendy (Teacher of the Deaf - Retired, Paediatric Cochlear Implant prgramme Guys and St Thomas NHS Foundation Trust) (HSC0821)

83 Independent Ambulance Association (HSC0915)

84 Independent Healthcare Providers Network (IHPN) (HSC0761)

85 Institute and Faculty of Actuaries (HSC0932)

86 JDRF UK (HSC0790)

87 Jameson, Jacqueline (HSC0505)

88 Keep Our NHS Public (HSC0819)

89 Lang, Mrs Hilary (HSC0780)

90 Local Government Association (HSC0011)

91 London Borough of Hackney (HSC0981)

92 MSI Reproductive Choices UK (HSC0961)

93 Macdonald, Andy (Network Manager (Retired), Greenhead College) (HSC0360)

94 Mactaggart, Dr. Iain (President, FMAX Technologies Inc.) (HSC0663)

95 Marie Curie (HSC0827)

96 Martin, Tony (Boss, Self employed) (HSC0645)

97 Matthews, Mr Rob (Retired Master Mariner, UK Merchant Navy) (HSC0773)

98 McGuinness, Mr Andy (Senior Public Affairs Advisor, Macmillan Cancer Support) (HSC0975)

99 McKesson UK (HSC0913)

100 Medical Protection Society (HSC0016)

101 Medical Technology Group (HSC0887)

102 Mencap (HSC0948)

103 Merriman, Richard (HSC0962)

104 Mind (HSC0985)

105 Mitchell, Bruce (HSC0455)

106 Motor Neurone Disease Association (HSC0904)

107 Mountain, Julia (HSC0646)

108 Mountlands Trust Limited T/A Lime Tree House (HSC0818)

109 NHS Confederation (HSC0005)

110 NHS Providers (HSC0987)

111 NHS Providers (HSC0003)

112 National AIDS Trust (HSC0967)

113 National Audit Office (HSC0982)

114 National Care Forum (HSC0939)

115 National Children's Bureau (HSC0936)

116 National Pharmacy Association (HSC0931)

117 National Voices (HSC0979)

118 Newman, John (HSC0695)

119 Novo Nordisk (HSC0924)

120 Nursing and Midwifery Council (HSC0971)

121 Openshaw, Mr Peter (Retired (formerly a Civil Servant), Latterly, Department for Transport) (HSC0947)

122 Our NHS Our Concern (HSC0854)

123 PAGB, the consumer healthcare association (HSC0917)

124 Parliamentary and Health Service Ombudsman (HSC0888)

125 Peacock, Mr Henry (Retired Local Government Officer, Local government) (HSC0375)

126 Peckham, Professor Stephen (Professor of Health Policy, University of Kent) (HSC0874)

127 Pharmaceutical Services Negotiating Committee (HSC0909)

128 Philips UKI (HSC0978)

129 Pickering (HSC0745)

130 Pinnell, Mr George (HSC0918)

131 Policy Research Unit in Health and Care Systems and Commissioning (HSC0748)

132 Primary Health Properties (HSC0933)

133 Professional Standards Authority for Health and Social Care (HSC0972)

134 Protect (HSC0029)

135 Protect Our NHS BANES (HSC0834)

136 RNID (HSC0890)

137 Repton, Dr Charles (HSC0229)

138 Rethink Mental Illness (HSC0919)

139 Revill, Dr David (HSC0573)

140 Roche Diabetes Care (HSC0128)

141 Royal College of GPs (HSC0950)

142 Royal College of Midwives (HSC0750)

143 Royal College of Nursing (HSC0916)

144 Royal College of Physicians (HSC0934)

145 Royal College of Physicians of Edinburgh (HSC0789)

146 Royal College of Psychiatrists; Centre for Mental Health; Mind; Mental Health Network of the NHS Confederation; Mental Health Foundation; and Rethink Mental Illness (HSC0958)

147 Royal College of Radiologists (HSC0929)

148 Royal Pharmaceutical Society (HSC0935)

149 Ruane, Dr Sally (Reader in Social Policy, De Montfort University, Leicester) (HSC0949)

150 Save Our Hospital Services Devon (HSC0844)

151 Simplyhealth (HSC0817)

152 Smith, Geoffrey (Retired, PPG) (HSC0017)

153 Smith, Professor Judith (Professor of Health Policy and Management and Director of Health Services Management Centre , University of Birmingham); Professor Jon Glasby (Professor of Health and Social Care, University of Birmingham); and Professor Robin Miller (Co-Director, Centre for Health and Social Care Leadership, University of Birmingham) (HSC0868)

154 Snell, Ms Nicola (Self-employed teaching/arts, AMET) (HSC0154)

155 Social Work England (HSC0797)

156 Somervaille, Dr Lillian (retired Public Health Consultant, NHS various) (HSC0137)

157 Specsavers (HSC0938)

158 Stewart, Ms Joan (HSC0815)

159 Sue Ryder (HSC0866)

160 Sustainable Care programme, University of Sheffield and partners (HSC0945)

161 Sutton, Ms Lucy (Policy Manager, Association of Directors of Public Health) (HSC0902)

162 Tallerman, Professor Maggie (Emerita Professor, Newcastle University) (HSC0792)

163 Terrence Higgins Trust (HSC0970)

164 The Almshouse Association (HSC0014)

165 The Association of Optometrists (AOP) (HSC0796)

166 The Association of the British Pharmaceutical Industry (ABPI) (HSC0861)

167 The Charlie Gard Foundation (HSC0895)

168 The Company Chemists' Association (HSC0804)

169 The Health Devolution Commission (HSC0922)

170 The Health and Care Professions Council (HSC0880)

171 The Kings Fund (HSC0001)

172 The LIFT Council (HSC0820)
173 The Nuffield Trust (HSC0002)
174 The Patients Association (HSC0892)
175 The Richmond Group of Charities (HSC0853)
176 The Royal British Legion (HSC0021)
177 The Royal College of Emergency Medicine (HSC0984)
178 The Royal College of Podiatry (HSC0921)
179 The Royal College of Surgeons of Edinburgh (HSC0778)
180 Tredgold, Dr Christopher (HSC0551)
181 Turner, Mrs Christine (N/A, N?A) (HSC0607)
182 UK Faculty of Public Health (HSC0026)
183 UNISON (HSC0886)
184 United Kingdom Freedom From Fluoride Alliance (HSC0010)
185 United Kingdom Freedom From Fluoride Alliance (HSC0953)
186 University of Bristol (HSC0013)
187 Vidal, Mr Michael (HSC0009)
188 Virgin Care (HSC0912)
189 Vyvyan, Michael (HSC0642)
190 Walton, Keith (Therapist, Keith Walton therapy) (HSC0223)
191 Watson, Mr Ken (HSC0449)
192 Williams, Mr Richard (HSC0404)
193 World Alliance for Mercury Free Dentistry (HSC0801)
194 Wortley, Dr Pam (Retired GP, NHS) (HSC0899)
195 Zutshi, Ms Mavis (HSC0833)

# List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website.

## Session 2019–21

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| 1st | Appointment of the Chair of NICE | HC 175 |
| 2nd | Delivering core NHS and care services during the pandemic and beyond | HC 320 |
| 3rd | Social care: funding and workforce | HC 206 |
| 4th | Appointment of the National Data Guardian | HC 1311 |
| 1st Special | Process for independent evaluation of progress on Government commitments | HC 663 |
| 2nd Special | Delivering core NHS and care services during the pandemic and beyond: Government Response to the Committee's Second Report of Session 2019–21 | HC 1149 |