Department of Health & Social Care

From the Rt Hon Sajid Javid MP
Secretary of State for Health and Social Care

6th July 2021

Dear Members of the Health and Social Care Committee,

Thank you for your insightful and timely report on the Government's white paper proposals for a Health and Care Bill, published on 14 May.

As you know, the fundamental aim of this legislation is to put into statute the requests the NHS made of Government in 2019, while making a number of other changes to support improvement across the health and care system. The Bill started with an engagement exercise led by the NHS and since then the Department has listened closely to health and local government stakeholders in developing legislative proposals. I want to build on that collaborative approach as we take this Bill through Parliament.

Since taking up this role, I have been clear that I will do whatever it takes to support the NHS. The legislation that has been developed by my Department, in close collaboration with NHS England, contains measures that will be profoundly important for our health and care system, as we build back better from the pandemic.

The Committee has made a series of valuable recommendations which have served to improve the Bill before it has even been introduced to Parliament, and I look forward to working with the Committee, and Parliament as a whole, as it further scrutinises the Bill in detail. Together we will ensure that the legislation delivers on the aims of promoting collaboration, reducing needless bureaucracy, improving accountability and helping to level up health outcomes across the country.

Turning to the recommendations you have already made in your report, I want to update you on how these have informed the drafting of the legislation.

Background

The proposals in this Bill are underpinned by the desire of this Government and the NHS to empower local health and care leaders to pursue new and innovative ways of delivering for people and communities. The Bill will be enabling, permissive and flexible, allowing the NHS and the wider health and care system to meet the challenges it faces now and in the future.

The Committee made a number of recommendations that have been incorporated into the Bill. There are some recommendations where the Government is sympathetic to the policy intent but where further policy development is required. I have instructed my officials to work with NHSE and other stakeholders on these issues and I will write following Introduction with further detail on how we intend to deal with those. There are also a small number of proposals which we cannot commit to meet at this stage, but on which the Government is already taking steps that I believe go some way to addressing the Committee's concern.

Integrated Care Systems (ICSs)

Turning first to the Committee's recommendations on ICSs, the Committee proposed that ICSs should be held accountable for the quality and safety of care through transparent CQC assessments. My officials have been working closely with the CQC and NHSE to develop detailed proposals to include in the Bill as an amendment. These new powers for the CQC are an opportunity not only to inform the public about the quality of health and care in their area, but also a way to review progress against our aspirations for delivering better, more joined up care across ICSs.

I agree, moreover, with the Committee that CQC assessment of ICSs should include consultation with patient groups and that we should explore how the CQC reviews could report on progress ICSs have make on the integration of information technology between primary care, secondary care and the social care sector.

The Committee recommended that the Bill should include a framework setting out the roles and responsibilities of both the Integrated Care Board (ICB) and the Integrated Care Partnership (ICP), and of the Chair of the ICP. I agree with this suggestion, and this will be included in the statutory guidance for both ICBs and ICPs, clearly describing how they come together coherently and how the roles and responsibilities of each may be supplemented locally under the proposed legislation. The same is true of your recommendation that NHSE should set out in guidance how the responsibilities and accountabilities of NHS trusts and foundation trusts align with these, which NHSE has addressed in the ICS Design Framework that has been developed with the extensive involvement of key stakeholders.

I welcome your proposal that a duty be placed on ICBs 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, and 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. I can confirm that the Bill will now ensure that ICBs have a duty to consult patients and carers when undertaking their functions. And we will continue to work closely with the NHS and carer organisations as we work up guidance for ICSs on the composition of ICBs.

The Committee made a number of recommendations in relation to membership of ICBs. First, you proposed that criteria should be set for appointments to ICBs by the Secretary of State. While NHSE will now be responsible for the appointment of chairs and chief executives to the ICB, we are working with them to develop a set of criteria for these appointments.

As regards the recommendation for the establishment of a UK-wide public register of people that are holding, have held, or are seeking to hold a position on an NHS board, my officials are examining options in this area and I hope to be able to update the Committee in due course.

The Committee also proposed that NHSE and the Department undertake a review of the adequacy of the training and support provided to board members. NHSE currently provides a range of training and development opportunities to ICS leads, chairs and non-executives. This comprises both formal and informal development opportunities including:

- NHSE currently provides a range of training and development opportunities to ICS leads, chairs and non-executives. This comprises both formal and informal development opportunities including:
- Current ICS leads and chairs meet at least bi-monthly with the NHS CEO and COO to share learning, in particular from the most advanced systems
- Broader ICS executive team engaged in regular “learning” set style events and international learning webinars to bring thought leaders together
- Executive level leaders have access to the Executive Suite which offers support options, webinars and resources, over 1,100 Executives have utilised this offer
- Current non-executive directors and chairs have access to a programme of worked commissioned from NHS Confederation which includes a range of activities including:

    - Bi-monthly ICS Chairs Network Meetings to support knowledge on ICS policy and legislation
    - Re-set group for network and community chairs focused on recovery
    - Webinar series with topics set by NEDs/chairs
    - Facilitation and logistical support for regional Chairs Networks
    - Engagement events focused on legislative changes and emerging issues
    - Monthly newsletters and dedicated FutureNHS platform

This is in addition to business as usual support provided through the NHSE Leadership Academy. As part of the move to statutory ICSs, this offer will continue to evolve and national guidance will be produced to further help board members, including designate ICS chairs and CEOs.

Finally, I am grateful to the Committee for your recommendation 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. The definition of 'healthcare' in s1(1) of the NHS Act 2006 includes mental healthcare, and I am pleased to be able to confirm that ICBs will have a duty to secure a comprehensive health system. Furthermore, ICBs will have to consider prevention as part of their role, and will have to plan to meet their community's health needs. The ICPs will also have to develop strategies to prevent ill health and promote health and wellbeing.

Social care

The Committee made a number of recommendations on social care, including a proposal for a duty to be placed on the Secretary of State to publish a 10-year plan with detailed costings within six months of the Bill receiving Royal Assent. I wholly agree that social care reform is a top priority, and this Bill represents just the first step on our path to reform, as we build back better after the pandemic, learning lessons from the last year. We will bring forward proposals this year. Social care has been at the heart of our pandemic response – we have provided billions of pounds to support adult social care, issued millions of items of free PPE, and prioritised care workers and residents for vaccination. Our manifesto made clear that we want a sustainable system, that meets people's needs whilst supporting health and care to join up services around people.

I am grateful for the emphasis placed by the Committee on the role of unpaid carers. As above, the Department has taken forward the proposal to include a duty to consult unpaid carers giving carers' representatives a voice in the ICB and ICP structures.

The report also called for the NHS to promote the health and wellbeing of unpaid carers. I agree that the health and wellbeing of carers is of great importance and thank the committee for raising this important issue. We will continue to work closely with carer representative organisations and the NHS to understand how the health service can support carers in their health and wellbeing.

The Committee is right to highlight the need to protect of carers' rights on discharge. We intend to set out roles, responsibilities and expectations of health and social care partners and patient/carer interests in future guidance rather than through legislation. The guidance will be informed by existing duties in relation to carers set out in the Care Act 2014.

The Committee recommended giving the CQC powers to give Ofsted-style ratings for local authority social care. While I agree there could be value in the CQC rating local authorities, we are in the early stages of developing the framework by which the CQC will assess performance. My officials are working with the CQC and stakeholders to develop a fair, transparent and robust approach that will drive quality and best possible outcomes for

services users.

The Committee's suggestion that CQC ratings include consideration of food standards in social care settings is already delivered by the CQC's existing regulatory functions in relation to providers. Regulation 14 of the Health and Social Care Act 2008 already requires providers to meet nutrition and hydration standards when providing care, and the CQC must refuse registration if there is non-compliance.

Workforce

The Committee recommended that the Bill should include provisions to require Health Education England (HEE) to publish independent annual reports on workforce shortages and future staffing requirements that cover the next five, ten and twenty years, and that these projections should also cover social care as well. You have also made this recommendation in your report on workforce burnout and resilience in the NHS and social care.

We will introduce a duty in the upcoming Bill to provide clarity on the purpose and role of each organisation in the system on workforce planning, particularly given the proposed abolition of Local Education and Training boards, the establishment of ICSs as legal bodies and the creation of regional people boards. Our proposal is to set these roles out in one document for the first time to provide transparency and therefore accountability for actions.

The health and care landscape will clearly be evolving over the coming years and the workforce duty we propose will provide an opportunity to ensure that accountabilities are clear as this happens. It is important that we have the clarity and flexibility to adapt and publishing a report on workforce planning and supply will set out in a clear and transparent way the role of the various players in a complex system.

Of course, we will need to align the legislative provisions with concerted non-legislative action on planning and supply, including clarifying the role of ICSs in workforce planning in statutory guidance that will come later down the line.

As a Government, we are alert to the need to invest in the workforce.

- We are making good progress on the 50,000 nurses commitment - with a 34% increase in applications to nursing and midwifery this year and we estimate there are 70,000 nurses and midwives in training this year.
- The Spending Review 2020 provided £260 million to continue to grow our NHS workforce and support commitments made in the NHS Long Term Plan.
- We expanded the number of places available for domestic medical students at schools in England by 1,500 in recent years – a 25% increase. This expansion was completed in September 2020

However, at this time, we do not agree that a requirement in primary legislation to publish long term workforce projections is needed in order to continue to invest. We will set an overall workforce strategy for the NHS through the mandates to NHSE and HEE, and how this all comes together on the ground is what's key in making a difference for our colleagues on the front line delivering the care.

With regard to social care, our proposed duty will include regulated healthcare professionals working in the social care sector, including for example, nurses, occupational therapists and physiotherapists. These are professions where the entry level to the profession is at undergraduate level with pre-registration education and training normally lasting three years.

You also recommended that workforce reports be undertaken in consultation with the Devolved Administrations (DAs). DHSC and Health Education England (HEE) already work collaboratively across the four nations on workforce planning. For example, on medical: the UK Foundation Programme Office (UKFPO) (which facilitates the operation and continuing development of the Foundation Programme for doctors) is jointly funded and governed by HEE and the four UK Health Departments. The UK Medical Education Reference Group meets regularly with membership including the four departments of health and National Education Scotland, Health Improvement and Education Wales, Northern Ireland and HEE alongside regular meetings with the DAs on Post Graduate Medical and Dental Education policy chaired on rotation by the medical directors.

On non-medical workforce, HEE has regular dialogue on planning, policy and workforce redesign with DA agencies (including National Education Scotland (NES) and Health Education and Improvement Wales). This also includes DA Chief Professional Officers and Regulators (NMC and HCPC) in design of workforce and professional practice policy. Recent examples include: Pandemic Critical care policy and planning, and Student Nurse Emergency standards and deployment.

We will continue to work collaboratively with the Devolved Administrations and their Arm's Length Bodies and will discuss sharing workforce planning data and policy intentions with them.

Accountability

I welcome the Committee's recommendations on the additional powers for the Secretary of State. You recommended that the Bill sets 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. I am pleased to be able to inform you that the clause allowing for directions to NHSE includes several transparency requirements, including that directions must be made in writing, be published as soon as is practicable and with a statement that the Secretary of State considers it to

be in the public interest.

This clause is designed to apply only to the functions that NHSE holds and will sit alongside the existing accountability mechanisms and processes for ensuring NHSE fulfil their duties to promote a comprehensive health service and deliver Government priorities.

The powers will ensure appropriate and transparent accountability between the Secretary of State and NHSE, the ALB that is tasked with managing the most important public service and institution in the country, and with those bodies for which NHSE has oversight functions. It will help ensure that NHSE is working effectively with other parts of the system including social care and public health, to support integration and tackle broader priorities such as health inequalities. For example, recognising the unique role the Secretary of State for Health and Social Care plays in the system, the Secretary of State could use the powers to request to see guidance developed by NHSE before it is published to ensure NHSE is working effectively with the wider system, including local authorities, and that the views of local authorities are represented and align with priorities in social care.

Similarly, the Committee called for clear criteria to be set out in the Bill for the Secretary of State to intervene in reconfigurations. Whilst the scope of the power as drafted is broad, we intend to set out further detail of how the process will work in practice and what is expected of all parties. I know that some members of the Committee will also be pleased to hear that we are now maintaining the Independent Reconfiguration Panel, which will help to ensure that Ministers receive the necessary advice and information before making decisions.

A further recommendation concerned the ALB Transfer of Functions power, use of which the Committee rightly said ought to be subject to the affirmative procedure. I can confirm that this is indeed the case. The clause provides for the use of the affirmative procedure in secondary legislation, after consultation with the affected ALBs and, where that ALB exercises functions in or on behalf of, the DAs.

Procurement

The changes being proposed to the procurement rules are the result of requests made by the NHS, which have garnered strong support from the wider system across multiple consultations. These reforms will give commissioners more discretion over when to use a competitive process to arrange services than at present, with proportionate checks and balances. The Committee recommended that the Department ought to establish a framework for monitoring new contracts annually.

We agree with the Committee's position that there needs to be appropriate transparency and scrutiny of the decisions made and the contracts awarded under the proposed new provider selection regime. The provider selection regime will set out expectations about

what and where decision-making bodies need to publish in relation to the contracts they have with providers. Commissioners will be expected to make decisions in the best interests of the patient, taxpayer and local population. To assist them in this, the new regime will also include a list of criteria that should be taken into consideration when deciding how and with whom to arrange services, this includes value for money and quality.

Implementation

Finally, the Committee made some useful suggestions about the implementation of the measures in the Bill. You stressed that the implementation period should fully take into account the fact that parts of the country will be at different starting points on this journey. And you highlighted the importance of ensuring 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.

We recognise the scale of the challenge facing the NHS post-pandemic, and that different parts of the country will be at different starting points. A core principle of the Bill is it that it will not be overly prescriptive, at its heart is a desire for flexibility and to allow local leaders to develop local solutions. Our intention is that all ICSs will be ready to perform core functions from April 2022, subject to the passage of the legislation, and NHSE will be undertaking preparatory work with systems over the course of the year. We do not consider it practical to have different start dates for different ICSs being established, or a dual system of running CCGs and ICSs. Such an approach could generate prolonged uncertainty and inconsistency at a time when systems need to focus on recovery.

I do want to thank the Committee for emphasising the importance of ICSs learning from best practice, and of capturing that learning. I agree wholeheartedly with this. NHSE is proactively supporting systems to share good practice, both on a regional and a national basis. This includes analysing development priorities to identify opportunities to join up learning and development through joint programmes of support and shared guidance, and gathering and disseminating case studies and examples of good practice.

Conclusion

I am hugely grateful to the Committee for the vital role you have already played in improving this legislation. I would also like to thank you and your officials for the flexibility you showed in agreeing to and conducting this expedited inquiry.

I and my officials look forward to discussing the Bill in greater depth with you once it has been introduced, and am confident that this landmark legislation will continue to benefit from your scrutiny and insight in the months ahead.

Yours ever,

RT HON SAJID JAVID MP

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From Rt Hon Jeremy Hunt MP

7 July 2021

Rt Hon Sajid Javid MP
Secretary of State for Health and Social Care

Sent by email

Dear Saj,

Thank you for your letter of 6th July regarding the Health and Social Care Bill. It is very welcome news that you have incorporated some of the recommendations from our report of 14th May. Ahead of the Bill's Second Reading I wanted to seek clarification on a number of the points you make.

Firstly, our report was very clear that the creation of Integrated Care Systems are welcome, "Provided that proper accountability mechanisms are put in place, particularly relating to the safety and quality of care". Whilst I was disappointed that such provisions are not currently in the Bill I welcome your commitment to include this important recommendation as a government amendment. It is worth pointing out that your predecessor stated the government was committed to ensuring:

"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".

I would therefore be grateful if you could confirm that this is still the intention and if this will be confirmed in the amendment or, if not required on the face of the Bill, during the Second Reading debate?

I was also very concerned to see that you have rejected our recommendation to introduce a statutory requirement for Health Education England to publish regular work force projections. The current proposals in the Bill simply set out that a report will be published every five years setting out what each organisation is responsible for when it comes to workforce planning. Whilst that is important to know I fail to see how that helps us understand what our actual workforce requirements are. It is great news that the government is making good progress regarding the 50,000 nurses commitment but we don't actually know if that is enough nurses, too many or the right amount. Or if government does they have not shared the projections this is based on so there is no way for Parliament to scrutinise or hold them to account on this figure. Our recommendation would rectify this situation.

It is disappointing that you have rejected our suggestion because you do not think "a requirement in primary legislation to publish long term workforce projections is needed in order to continue to invest". It is obviously not needed to continue to invest but such a duty would mean the government and parliament would know if we are investing the right amount. I would urge you to reconsider this recommendation. If you do not think this is the right solution I would be happy to see alternative proposals that will address the long term workforce issues facing the NHS. Your predecessor helpfully indicated that he was "looking forward to working with the Committee to think about how we can make sure that there is always an assessment of what is needed, not least with the passage of the health and care Bill in the forthcoming session". I would welcome confirmation that you share that commitment as the current measures in the Bill on workforce are inadequate.

Finally, on social care I recognise that you have repeated the commitment to bring forward proposals this year. It would reassure the users of our social care system and the many who work in it that these will be meaningful proposals if you could commit to either an amendment introducing a ten year plan or assured the House that this was your aim during the debates on the Bill.

Yours sincerely,

Rt Hon Jeremy Hunt MP
Chair, Health and Social Care Committee