Working Paper

Summary and commentary on the issue of accountability in the Health and Care Bill 2021

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The White Paper

In the White paper (*Integration and Innovation: working together to improve health and social care for all*, February 2021), the Government set out a framework of effective national oversight of the NHS via legislative proposals aiming at ensuring that the public and parliament will be able to hold health and social care decision-makers to account. It included proposals for reforms to the mandate to NHS England to allow for: more flexibility of timing; the power to transfer functions between Arm's Length Bodies (ALBs); and the removal of time limits on Special Health Authorities. It promised an improved level of accountability to be introduced within social care, with a new assurance framework allowing greater oversight of local authority delivery of care, and improved data collection. It also promised to introduce greater clarity in the responsibility for workforce planning and a clear line of accountability for service reconfigurations with a power for ministers to determine service reconfigurations earlier in the process than is presently possible (p.12).

The main proposals to strengthen the accountability lines were:

- Formally merge NHS England and NHS Improvement (which consists of Monitor and the NHS Trust Development Authority).
- Ensure the Secretary of State for Health and Social Care (SoS) has appropriate intervention powers with respect to relevant functions of NHS England. These new intervention powers will increase the SoS's accountability to Parliament.
- ICSs take a greater level of responsibility. This will be followed by measures to strengthen the role of government and Parliament. The Department of Health and Social Care (DHSC) will play a critical role in overseeing the health and care system and ensure strong alignment between public health, healthcare and social care.
- The DHSC will support the independence and accountability of ICSs, and the SoS will play an important role in ensuring the effective working of integration of public health, healthcare and social care.
- There will be a more flexible mandate for NHS England, which will make it easier for the SoS to set objectives for the body.
- When it comes to significant service change, the SoS will be able to intervene in local service reconfiguration changes where required. This will ensure accountability and timely access to decision-making for them and the people they represent.
- On public health, it will be made easier for the SoS to direct NHSE to take on specific public health functions.

- Ensure a more agile and flexible framework for national bodies that can adapt over time. If the power to transfer functions is used, additional safeguards will be put in place to enable further scrutiny.
- Remove from legislation the 3-year time limit for Special Health Authorities.
- Improve accountability in the social care sector by introducing an enhanced assurance framework to provide a greater level of oversight of the delivery of social care by local authorities. The White paper explains that reforms to social care and public health will be dealt with outside this Bill (p.28).
- Introduce a duty for the SoS to publish a report in every Parliament which will support greater clarity around workforce planning responsibilities.
- Introduce power to impose capital spending limits on Foundation Trusts (FTs), in line with NHS England's recommendation.

The Health and Social Care Bill 2021

The provisions of the Bill are targeted towards a number of broad areas, like 'promoting working together in the health service to integrate care, reducing bureaucracy, improving accountability and enhancing public confidence', as well as a variety of specific topics. (*Delegated Powers – Memorandum*, July 2021, p.2). This issue of accountability is a central theme as it runs through all tiers of the healthcare system. In a hierarchical system such as the NHS, there is a vertical chain of accountability running from the lower levels of commissioners and providers of health services to the upper level of the DHSC and the SoS who is ultimately accountable to parliament and the people. In addition to this hierarchical/vertical type of accountability, there is present a second type of accountability, characterised as 'horizontal', which relates to organisational actors of 'network' types of co-ordination. Examples of such co-ordination are the proposed 'integrated care partnerships' which feature in the Bill, and provider collaboratives and co-operations at place level which are hardly mentioned in the Bill. These two types of accountability will be discussed further at the final section of this paper. The main issues relating to accountability as outlined in the Bill are:

'Triple Aim' duty

According to the White paper the aim to achieve integrated care will be supported by 'measures including improvements in data sharing and enshrining a 'triple aim' for NHS organisations to support better health and wellbeing for everyone, better quality of health services for all, and sustainable use of NHS resources' (WP, p.11). In the Bill, a new duty is to be imposed on bodies that arrange NHS services (NHSE and ICBs) and NHS providers of care (Trusts and Foundation Trusts) to have regard to the effect of their decisions on the health and wellbeing of the people of England, on the quality of services provided by other NHS bodies and on the sustainable resource use of other NHS bodies (operationally known as the "Triple Aim"). NHSE will have power to publish guidance on this duty. (Memorandum, p. 7). The 'triple aim' duty is relevant to the accountability since all parts in the hierarchy will be

required to meet its objectives and will be held accountable for it. In the Bill the 'triple aim duty' is referred to as the 'duty to have regard to wider effect of decisions'.

Delegated powers and rationale

As already outlined in the White Paper, the Bill includes a number of new powers of intervention the SoS will have over, for example, NHS England (NHSE) and other ALBs, or over major service reconfigurations. The Bill also contains a number of powers delegated to NHSE in particular in relation to Integrated Care Boards (ICBs). The Bill allows for a number of issues to be dealt with in delegated legislation at later stages (rather than specified in the Bill or in further primary legislation). The rationale for this was the need to: a) avoid too much technical and administrative detail on the face of the Bill; b) provide flexibility for responding to changing circumstances; and c) allow detailed administrative arrangements to be set up and kept up to date within basic structures and principles that are set out in primary legislation, subject to Parliament's right to challenge inappropriate use of powers. (*Delegated Powers – Memorandum*, p.3)

Secretary of State powers

One of the main features of the Bill is that it allows the SoS to exercise a large degree of control over the running of the NHS in general, and NHSE in particular. The Bill 'confers functions on the SoS to direct NHSE as well as other NHS bodies in specific circumstances…' (*Memorandum*, p.2). Specifically, Part 3 of the Bill confers power on the SoS to transfer functions between any of a defined group of relevant Non-Departmental Public Bodies (NDPBs), and to delegate functions of the SoS to these NDPBs. These are 'Henry VIII' powers (see Appendix 1). But these functions do not extend to 'making NHSE redundant': 'Regulations under this section may not transfer a function of NHSE if the SoS considers that to do so would make NHSE redundant' (Part 3, 87(3)).

SoS Mandate and financial directions to NHSE

As promised in the White Paper, greater flexibility is being introduced in relation to the mandate. Under Section 13A of the NHS Act 2006, the SoS has a duty to lay in Parliament and publish a mandate to NHSE before the beginning of each new financial year. The mandate will remain the primary statutory mechanism for Government to set objectives and requirements for NHSE. However, this Bill proposes that the mandate duty should become more flexible, so that a mandate can be set at any time, ensuring there is always a mandate in place, and will remain in force until it is replaced by a new mandate. Currently, a mandate can only be replaced during the financial year it relates to in very limited circumstances. Clause 3 (2) (a) removes the requirement for a mandate to be set before the start of each financial year.

The mandate must include objectives that NHSE has a duty to seek to meet and must also specify the limits on capital and revenue resource use that the SoS has set for the purposes of section 223D. As a consequence of removing the statutory link between the mandate and the annual financial cycle, it is proposed that NHSE's annual limits on capital and revenue resource use are given statutory force through the financial directions (given under section

223D) [Clause 3(3)]. It will become a legal duty for the SoS to give such directions, and to both publish them and lay them in Parliament, to ensure continued transparency to Parliament for the financial allocations within which NHSE is expected to deliver mandate objectives and requirements, as well as its wider functions.

NHSE has a legal duty, under section 13T of NHS Act 2006 to set out in its business plan how it intends to meet objectives in the mandate. Should the Government replace a mandate within its first year, NHSE will not be required to revise its own business plan for that year but will need to set out in its annual report the progress it has made on any mandates in force for the relevant year [Clause 3(4) and Clause 3(5)]. Having considered NHSE's annual report, under section 13U of the NHS Act 2006, the SoS must then lay in Parliament and publish an annual assessment of its overall performance during the financial year – including performance against the mandate (EN, p.13).

There will continue to be a legal duty, under section 13A(8) for the SoS to consult NHSE, Healthwatch England (representing patients) and any other persons that the SoS considers appropriate before setting objectives in a mandate. Every mandate will also continue to be laid in Parliament with any requirements that may be included requiring underpinning through negative resolution regulations.

Power over NHSE

The Bill will abolish Monitor and the NHS TDA and transfer their functions to NHSE. In recognition of the expanded powers and responsibilities of NHSE, the Bill seeks to introduce an additional accountability mechanism to support the SoS in their democratic oversight of NHSE.

Clause 37(1) amends the NHS Act 2006 and inserts four new sections (13ZC, 13ZD, 13ZE, and 13ZF) which provide the SoS with powers to give directions to NHSE. New section 13ZC gives the SoS the power to direct NHSE in relation to their functions. The SoS cannot use this power to direct NHSE not to perform a duty. The intention is for NHSE to continue to exercise its functions as an Arm's Length Body as it does now, with the Mandate remaining the primary mechanism through which the SoS will set out the priorities that NHSE should be seeking to achieve. The Framework Agreement DHSC and NHSE will continue to set the parameters within which NHSE should operate and how DHSC and NHSE will interact with each other. The power of direction supplements these mechanisms. Section 13ZD sets out the exceptions to this power. The clause also removes section 13Z2 (failure to discharge functions) of the NHS Act 2006 and introduces new section 13ZE. This section continues (as in previous section 13Z2 of NHS Act 2006) to confer a power on the SoS to intervene in cases of significant failure of NHSE to carry out any of its functions. This is in line with similar powers in the case of significant failure of the other arm's length bodies. The difference here is that it also applies to directions in 13ZC. If NHSE fails to comply with a direction in 13ZC, the SoS may consider this a significant failure and will have to set out the reasons why this is the case. NHSE has a wide range of functions in relation to the health service. As a result, in the event of significant failure, it might be appropriate for the SoS to intervene in a particular case, for example if NHSE failed to allocate funds to a particular ICB or if it failed to commission a service as

required by the NHS Act. The SoS may perform the functions themselves or direct another person to do so. The clause also introduces section 13ZF which gives the SoS powers to direct NHSE to provide information. A direction under this section also allows for a direction to NHSE to use any powers they hold to obtain this information form others (such as ICBs) if required. According to the Explanatory Notes (EN), the powers conferred by this new section are not intended to be powers that the SoS would use frequently to intervene in the affairs of NHSE. NHSE will remain an ALB and will therefore continue to exercise the majority of its functions as it does now. The new power is designed to supplement the existing mechanisms by giving the SoS the ability, where he deems it appropriate, to set direction and to intervene in relation to NHSE's functions. Directions could be issued on specific matters or on a standing basis. This will be done in a transparent way. Any directions made by the SoS must be made in the public interest, in writing, and published. (EN, p. 24).

One of the powers conferred on the SoS to direct NHSE relates to commissioning of specialised services. Section 3B of the NHS Act 2006 is amended [Clause 2]. This clause relates to the power of the SoS to require NHSE to commission certain specialised services that are not appropriate for commissioning by CCGs (or, in future, ICBs) – for example, patients with rare cancers, genetic disorders or complex medical or surgical conditions. Under subsection (2), the test for the SoS to prescribe a service to be commissioned by NHSE is amended to clarify that the SoS can prescribe a service if they deem it appropriate for NHSE, or someone acting on NHSE's behalf, to commission it. Subsection (4) requires the SoS to explain to NHSE his reasoning, if he refuses a request from NHSE to revoke provisions made in regulations that specify which services NHSE may commission.

Clause 33 inserts a new Section 1GA into the NHS Act 2006. Subsection (1) sets out a duty on the SoS to publish, at least once every five years, a report describing the system for assessing and meeting the workforce needs of the health service in England.

A further power of direction to NHSE relates to commissioning of public health. NHSE currently commissions a range of services, including national immunisation and screening programmes, under a delegation (enabled by Section 7A of the NHS Act 2006) as set out in an NHS Public Health Functions Agreement with the SoS. However, the SoS cannot require NHSE, or any other NHS body to take on a delegated public health function. This potentially exposes the SoS to a position where he is unable to effectively deliver an aspect of his public health duties. Clause 34 replaces section 7A in the NHS Act 2006. Subsections (1) and (2) allow for any of SoS's public health functions to be exercised by NHSE, an ICB, a local authority that has duties to improve public health, a combined authority, or any other body that is specified in regulations. Clause 35 introduces a new section 7B into the NHS Act 2006 and allows the SoS to direct one or more relevant bodies to exercise any of the public health functions of the SoS. Subsection (2) of section 7B defines relevant bodies as NHSE and ICBs. Subsection (3) ensures that any functions that should not be capable of being delegated (by the relevant bodies) can be prescribed and any functions that may be delegated but that need to be more closely controlled can be subject to conditions. Clause 36 introduces new sections 7C, 7D and 7E in the NHS Act 2006. These relate to power of direction by the SoS related to investigation functions. Section 7C(9) clarifies that the investigation functions are the functions which were

previously exercised by the Trust Development Authority (TDA) (Healthcare Safety Investigation Branch), Directions 2016 and Directions 2018.]

Power over intervention in service reconfiguration

As stated in the White Paper ('*we are therefore proposing to broaden the scope for potential ministerial intervention in reconfigurations, creating a clear line of accountability, by allowing the Secretary of State to intervene at any point of the reconfiguration process*,' WP, 5.84, p.50), there are provisions in the Bill which allow the SoS to be involved in service reconfiguration at an earlier stage in the process. Most planned service changes are developed and implemented at local or regional levels by commissioners. According to the *Explanatory Notes*, the current system for reconfigurations works well for the majority of changes, and this will be left in place for many day-to-day transactions. The aim of the Bill is to address the minority of cases which are complex, a significant cause for public concern, or where Ministers can see a critical benefit to taking a particular course of action. Cases such as these can lead to difficult debate and lengthy processes. The SoS is currently only able to intervene in such cases upon receiving a local authority referral. Following a referral, the SoS typically asks the Independent Reconfiguration Panel (IRP) to provide advice and recommendations. After receiving these, the SoS will communicate his final decision. Whilst this can help with difficult cases, referrals can often come very late in the process meaning Ministers must account for service changes in Parliament without often having been meaningfully engaged on them themselves.

The provisions on service reconfiguration in the Bill will add a new discretionary power to the NHS Act 2006 for the SoS to give a direction to NHS bodies or providers requiring a reconfiguration to be referred to him instead of being dealt with locally [Clause 38]. The SoS will be able to use this call-in power at any stage of the reconfiguration process. Clause 38 amends the NHS Act 2006, to insert a new section, 68A. Section 68A provides for a new Schedule 10A to confer intervention powers on the SoS in relation to the reconfiguration of NHS services. Paragraph 2 (of schedule 10A) places a duty on the NHS commissioning body (i.e. NHSE or ICBs) to notify the SoS when there is a proposal to reconfigure services. Paragraph 4(1) gives the SoS the power to give a direction to call in any proposal relating to a service reconfiguration. The direction is given to the NHS commissioning body. Paragraph 4(2) allows the SoS to take on the decision-making role of the NHS commissioning body. The SoS must then inform the NHS commissioning body of their decision. Paragraph 4(3) provides for the variety of decisions the SoS may choose to take when giving a direction for the reconfiguration of NHS services (including power to retake any decision previously taken by the NHS commissioning body). When the SoS has made a decision, he must publish any decision made about a reconfiguration and notify the NHS commissioning body of the decision (Schedule 10A, 4(4)). Paragraph 6 gives the SoS the power to direct an NHS commissioning body to consider a reconfiguration of NHS services. NHS commissioning bodies are required to consider the proposals from the SoS. During the SoS's review and decision-making process, the relevant NHS commissioning body, NHS trust or NHS FT must

give the SoS any information or other assistance that the SoS requires for the purposes of carrying out any functions under this power (Sch 10A, 7).

Although the White Paper expressed the intention to abolish the Independent Review Panel (IRP) (WP, 5.84, p.50), this intention is absent from the Bill. According to the Explanatory Notes, the process on service reconfiguration contained in the Bill means that the IRP role will adapt to the new process, including getting involved earlier in the process which will be similar to what it did when first set up in 2003. Future guidance will clarify NHS bodies' duty to notify the SoS of reconfigurations and how the SoS may use expert advice, including the IRP. (EN, p.27).

NHSE power and functions

The legal name of the NHS Commissioning Board will be changed to NHSE (Clause 1, and Schedule 1).

Clause 4 is about NHSE's duty to 'have regard to wider effect of decisions'. This provision, which is to be inserted in the NHS Act 2006 as the new section 13N, sets out a new duty (i.e. the 'triple aim duty'), which also applies to the other 'relevant bodies'. The 'relevant bodies' are ICBs (Clause 19, new section 14Z43), NHS Trusts (Clause 43, new section 26A) and NHS FTs (Clause 57, new section 63A). The reference in the subsection to "all" likely effects means that NHSE will have to consider, under subsections (b) and (c), the effects of the decision both on its own quality of services and resource use and those of other relevant bodies. (EN, p.49).

Clause 5 refers to the duty of NHSE to involve and consult individuals to whom health services are provided (including carers) when exercising its commissioning functions. This is not a new duty, except for the insertion of 'carers' in the NHS 2006 Act. According to the Bill, 'In section 13Q of the NHS Act 2006 (public involvement and consultation), in subsection (2), after "individuals to whom the services are being or may be provided" insert "and their carers and representatives (if any)."

Clause 7 refers to the powers NHSE has to delegate functions to ICBs. The clause amends the NHS Act 2006 to insert new provisions (13YB) that allow NHSE to direct an ICB to exercise any of its relevant functions, even in the absence of agreement between NHSE and ICBs to enter into section 65Z5 arrangements (i.e. 'joint working and delegation arrangements'). But, the SoS will be able to make regulations under subsection 13YB(3) which can specify any limits or conditions on the functions that NHSE may delegate to ICBs under this clause (EN, p.50). NHSE is also given the power to limit the ability of ICBs to arrange for other bodies to carry out these functions, under Subsection 13YB(4). NHSE may also make payments to an ICB in relation to the exercise of the relevant function, under subsection 13YB(6). Subsection 13YB(8) requires NHSE to publish any directions which delegated functions to ICBs under subsection (1). This is so that it is clear who is exercising which of these relevant functions – NHSE or ICBs. An ICB that has been directed to exercise a function as part of these arrangements is liable for the exercise of that function (subsection (9)). (EN, p. 51)

In relation to achievement of 'sustainable use of NHS resources' (which is part of the 'triple aim duty'), the *White Paper* had proposed to create a power to impose capital spending limits on Foundation Trusts' (WP, 3.11, p. 23 & 5.19, p. 37). Accordingly, in Clause 52, the Bill gives

a new power to allow NHSE to set capital spending limits for FTs. The FT limit would be set on an individual basis in respect of a named FT for a specified period (expected to be a financial year), and the limit would automatically cease at the end of that period [Clause 52(1) and (2)]. Subsection (3) and (4) places a duty on NHSE to consult with the FT before the order is made and requires NHSE to publish the order so that it is in the public domain. The power is intended to only be used on a FT where there is a clear risk of an ICS breaching its system capital envelope as a result of non-cooperation by a FT, and other ways of resolution have been unsuccessful (EN, p.16). Section 42C(1) requires NHSE to produce guidance on the use of its power to make orders (i.e. in relation to imposing capital spending limits on FTs) , and subsection (2) requires NHSE to consult with the SoS before publication of such guidance. (EN, p. 87).

Another form of vertical accountability is NHSE's oversight of ICBs via performance assessment. New section 14Z57 stipulates that NHSE must conduct and publish a performance assessment of each ICB in respect of each financial year. Under 14Z57(3), the assessment must, in particular, include an assessment of how well the ICB has discharged its duties concerning the improvement in quality of services (14Z34), reducing inequalities (14Z35), obtaining appropriate advice (14Z38), public involvement and consultation (14Z44), financial duties (223GB to 223O) and the duty to have regard to assessments and strategies (section 116B(1) of the Local Government and Public Involvement in Health Act 2007).

New section 14Z59(1) refers to the course of action NHSE can take when it considers an ICB to be failing or to have failed to discharge any of its functions, or that there is a significant risk that an ICB will fail to do so. Under subsections (3), (4), (5) and (6), NHSE may: direct the ICB or chief executive of the ICB to discharge any of its functions; terminate the appointment of the chief executive and direct the chair and other members of the board to appoint a replacement of their direction; exercise any function on behalf of the board or direct another ICB to perform functions specified by NHSE; exercise any functions of the chief executive or direct a chief executive of another ICB to perform functions specified by NHSE. Under subsection (8), the ICB is required to cooperate with any chief executive who is directed to exercise its functions.

Oversight of NHS Trusts

Clause 44, subsection (1), amends the NHS Act 2006, and subsection (2) inserts new section 27A into the NHS Act 2006, which gives NHSE the power to monitor NHS trusts established under section 25 of the NHS Act 2006 and to provide them with advice, guidance or other support. This carries across the function that the TDA was previously directed to carry out.

Clause 45 inserts a new section 27B which gives NHSE the power to give directions to NHS Trusts established under section 25 of the NHS Act 2006 on the exercise of their functions. The TDA previously had this power. Under subsection (2), clause 45 gives NHSE the equivalent power to direct NHS Trusts as is held by SoS under section 8 of the NHS Act 2006. If an NHSE direction under this subsection conflicts with a SoS direction under section 8 of the NHS Act 2006, NHSE's direction under this clause would have no effect.

Clause 47 inserts a new section 27D into the NHS Act 2006 which places a duty on NHSE to make recommendations to the SoS if it considers that the SoS ought to make an intervention order. These are again functions taken over by the TDA. NHSE has also taken over Monitor's responsibility in authorising an NHS trust to become a FT (Clause 48). Subsection (3) of Clause 48 amends section 35 so that authorisation may only be given for FT status if the SoS approves the authorization. NHSE also has the power to dissolve an NHS Trust on the approval of the SoS. Either of them may make a dissolution order after the completion of a consultation, except in cases where it is a matter of urgency.

Clause 49 gives NHSE the power to appoint the chair in the board of directors for an NHS Trust. This replaces the SoS's power to appoint the chair. The TDA was previously directed by the SoS to appoint the chair of NHS trusts under the 2016 Directions.

Clause 50 inserts new paragraphs into schedule 5 of the NHS Act 2006, which allow NHSE to set financial objectives for Trusts and require NHS Trusts to meet any financial objectives set by NHSE.

ICBs duties and functions

ICBs will be able to exercise their functions through 'place-based' committees (while remaining accountable for them) and they will also be directly accountable for NHS spend and performance within the system. (EN, p.17). A new section 14Z26(2) of Clause 13 states that, the outgoing CCGs are required to propose a constitution for the new ICB in their area, **for consideration by NHSE**. Under section 14Z26(4), NHSE must give effect to a proposed constitution unless NHSE consider the proposal inappropriate. NHSE is required to determine the terms of an ICB's constitution if a CCG or group of CCGs propose an inappropriate constitution or fail to consult appropriately on the terms of the constitution. (For the governance arrangements of ICBs and the duty to have a constitution, see Marie's paper).

Relevant to the issue of accountability is that, under Clause 13, Schedule 2, Part 1, para 4, the chair of each ICB is to be appointed by NHSE and approved by the SoS. Under para 5, the ICB constitutions must not provide for anyone other than NHSE to remove the chair from office. The power for NHSE to remove the chair from office must be subject to the approval of the SoS. Under para (6), the chief executive of the ICB must be appointed by the chair, with the approval of NHSE. Under paragraph (14), the constitution must detail the process for how the constitution can be amended. This should include provision allowing NHSE to approve any amendments to the constitution as well as provision for NHSE to amend the constitution on its own initiative. In part 2 of Schedule 2, under paragraph (20), an ICB may enter into externally financed development agreements, for example, for the development of premises for use for the purposes of the health service. This must be approved in writing by the SoS (sub- paragraph (1)). Under paragraph (21) of Schedule 2, part 2, an ICB must keep proper accounts and prepare annual accounts in respect of each financial year. NHSE, with the approval of the SoS, may direct an ICB to prepare accounts for a specified period, by a specified date, and specify how the accounts must be prepared.

Clause 19 specifies the duties of ICBs. Subsection (3) of 14Z43 provides that ICBs must have regard to guidance on the discharge of the 'triple aim duty' published by NHSE under new section 13NB.

New section 14Z49 (Clause 19) stipulates that NHSE must publish guidance for ICBs on the discharge of their functions. ICBs must have regard to this guidance. New section 14Z50 makes provision with regard to commissioning plans. Section 14Z50(1) stipulates that each ICB, and its partner NHS trusts and NHS FTs, must prepare a plan before the start of each relevant period to set out how it will exercise its functions over the next 5 years. Under 14Z50(4), this plan must be published and sent to NHSE, the relevant Integrated Care Partnership (ICP) and any relevant Health and Wellbeing Boards.The ICB and its partner NHS Trusts and NHS FTs are required to consult the population when preparing or revising this plan, and must also involve each relevant Health and Wellbeing Board (HWB) in the preparation or revision (14Z52 (2 & 3)). In particular the board must ask the HWB whether the draft 'takes proper account of each joint local health and wellbeing strategy' (14Z52 (4)). The HWB is required to respond with its opinion on the forward plan and may also give its opinion to NHSE (14Z52 (5) & (6)). Where a HWB gives an opinion to NHSE, it must also give a copy to the ICB. All published forward plans must include: a summary of the views of individuals consulted, an explanation of how those views were taken into account, and a statement as to whether the relevant HWBs agreed that the plans have due regard to the joint health and well-being strategy or strategies (14Z52 (8).

Each ICB and its partner NHS Trusts and NHS FTs must prepare a plan setting out their planned capital resource use (Clause 19 – 14Z54), giving a copy to the ICP for the board's area, each relevant HWB, and NHSE. Additionally each ICB must prepare an annual report on how it has discharged its functions in the previous financial year. This report is to be published and sent to NHS England.

ICPs duties

Each ICB and its partner local authorities is required to establish an Integrated Care Partnership (ICP), which is a joint committee of these bodies (Clause 20, 116ZA (1). The ICP will be tasked with developing an 'integrated care strategy' to address the health, social care and public health needs of its system (Clause 20, 116ZB (1)). The strategy must detail how the needs of an area will be met by either the ICB, NHSE, or the local authorities. It must also consider how NHS bodies and local authorities could work together to meet the local needs using section 75 of the NHS Act 2006[1] (Clause 20, 116ZB (2)) and the strategy may also state how health-related services could be more closely integrated. In preparing the strategy the ICP must have regard to the NHS mandate and guidance published by the SoS (Clause 20, 116ZB (3)) and involve the Local Healthwatch and people who live or work in the ICP's area

[1] Section 75 of the NHS Act 2006 provides the legal basis under which local authorities and health bodies can work together to improve health and social care provision. This includes making arrangements for flexible funding and working, such as arranging for the pooling of budgets and delegating responsibility for commissioning health related functions to the other.

(116ZB (4)). Under 116ZB (7), the integrated care strategy must be published and shared with each responsible local authority , and the relevant ICB in that area.
The *ICS Design Framework* policy document suggests that the ICP will need to be transparent with formal sessions held in public. Its work must be communicated to stakeholders in clear and inclusive language. Copies should be sent to local authorities, and ICBs if local authorities span multiple ICBs. When ICBs and local authorities receive a strategy from another ICP they must prepare a 'joint local health and wellbeing strategy' setting out how the assessed needs in relation to the responsible local authority's area are to be met by the exercise of functions of— (a) the responsible local authority, (b) its partner integrated care boards, or (c) NHS England, unless the existing joint local health and wellbeing strategy is sufficient (Clause 20 (5)). Local authorities are required to share 'Joint Strategic Needs Assessments' with the ICPs that overlap with the area of the local authority (Clause 20 (3)). Clause 20 (6) substitutes section 116B which places a requirement for local authorities and ICBs to have regard to the integrated care strategy, as well as the joint strategic needs assessment, and the joint local health and wellbeing strategy when exercising their functions (subsection (1)).

Integrated Care Systems: Financial controls

Clause 21 Is about NHSE's financial responsibilities, and substitutes sections 223C to 223E of the NHS Act 2006. New Section 223C sets out that NHSE must exercise its functions with a view to ensuring that total health expenditure in respect of each financial year does not exceed the aggregate of any sums received in the year by NHSE and ICBs.
Financial duties of NHSE: controls on total resource use. Section 223D sets out that NHSE must exercise its functions with a view to ensuring that total capital resource use does not exceed the limit specified in a direction by the SoS and that total revenue resource use does not exceed the limit specified in a direction by the SoS. In this section, total capital and revenue resource use are the resource use of NHSE, ICBs, NHS trusts and NHS FTs taken together (See also Clause 22). Under section 223D (4), a direction specifying a limit in relation to a financial year may be varied by a subsequent direction only if—(a) NHSE agrees to the change, (b) a parliamentary general election takes place, or (c) the SoS considers that there are exceptional circumstances which make the variation necessary. Under 223D (5), the SoS must publish and lay before Parliament any directions under this section.
Clause 23 omits sections 223H to 223J and inserts a number of new sections. New section 223GB (inserted after section 223GA) allows NHSE to impose financial requirements on ICBs in relation to their management or use of financial or other resources. Under subsection (2), these requirements may include limits on expenditure or resource use. However, NHSE may not use this power to impose limits on the use of revenue resources by an ICB for the purposes of administration, unless the SoS has ordered NHSE to do so.
Under new section 223GC, ICBs must operate with a view to ensure that the expenditure does not exceed the aggregate of any sums received by an ICB within that financial year. NHSE may specify descriptions of income and expenditure that should or should not be counted for the purposes of reaching financial balance, or the financial year in which they are counted.

Joint financial objectives for ICBs. Under new section 223L (substituting sections 223H to 223J), NHSE can set joint financial objectives for ICBs and their partner NHS trusts and NHS FTs, who must operate with a view to achieving these objectives.

Financial duties of ICBs: use of resources. Under new section 223N, ICBs and their partner NHS trusts and NHS FTs must operate with a view to ensuring that the local capital resource use and local revenue resource use does not exceed the limits specified by direction from NHSE in that financial year. Under subsection (3), where an NHS trust or NHS FT is partner to more than one ICB, NHSE can specify how resources should be apportioned to one or more different ICBs. Under subsection (4), NHSE can also specify what expenditure can or cannot be considered capital resources or revenue resources for the purpose of these provisions.

New section 223O allows NHSE, under direction of the SoS, to give direction to an ICB and its partner NHS trusts and FTs, in order to ensure that they do not spend more than a specified maximum amount of local capital resource or local revenue resource. Under subsection (2), NHSE can also specify what resources are or are not to be considered as capital resources or revenue resources for the purpose of these provisions.

New section 223P allows the SoS to specify which resources must, or must not, be treated or taken into account as capital resources or revenue resources for the purposes of section 223D, 223E, or 223N, or 223O.

Clause 24, new section 223LA states that an ICB and its partner NHS trusts, and NHS FTs must exercise their functions with a view to ensuring that local health expenditure does not exceed the aggregate of any sums received by them in the year. This clause is intended to be commenced later once the sector is prepared to move to more system financial accountability, which requires the scope of the expenditure financial duties to be expanded. New section 223LA will be inserted instead of section 223GC (which will be omitted).

Additionally, under Clause 9, NHS England may direct ICBs that a designated amount of the annual payment is to be used for purposes of the integration of health services with health-related or social care services, through the Better Care Fund. NHS England can do this where the Secretary of State has given a direction about the use by NHS England of the annual amount paid to them for purposes relating to service integration.

Joint working

Clause 60 is about joint working and delegation arrangements. It inserts new provisions into the NHS Act 2006. Under section 65Z5(1), any of the 'relevant' bodies set out or prescribed under subsection (2) may arrange for one of its functions to be exercised by or jointly with one of the other bodies under subsection (2), or a local authority, or a combined authority. Under subsection (2), the parties jointly exercising the function may set up a joint committee in order to exercise the function. Under subsection (3), the parties jointly exercising the function may also establish and maintain a pooled fund in order to exercise the function. Under subsection (4), the parties jointly exercising the function may agree between themselves the terms of their respective liabilities in relation to the joint exercise of the function. Regulations made under section 65Z5(3) may also impose conditions on what functions can be placed in a joint committee and how it should operate. Under section

65Z7(1), NHSE can issue guidance concerning the joint working and delegation arrangements set out under sections 65Z5 and 65Z6. Under 65Z7(2), all 'relevant' bodies listed under section 65Z5(2) must have regard to that guidance. Under 65Z7(3), section 75 of the NHS Act 2006, which details arrangements between NHS bodies and local authorities, is amended so that where a combined authority is exercising an NHS function as part of the arrangements under section 65Z5 or 65Z6, it can be treated as an NHS body.

New sections 7B and 65Z5 create additional ways in which the functions of one person or body may be exercised by another. New section 7B enables the SoS to direct NHSE or an ICB to exercise the SoS's public health functions, and new section 65Z5 enables a variety of bodies to arrange for another body to exercise their functions either for them, or jointly with them. These new provisions add to the existing power for the SoS to make arrangements under section 7A for NHSE, a CCG or a local authority to exercise the SoS's public health functions ("section 7A arrangements"), and the existing power in section 75 for local authorities and NHS bodies to work jointly ("section 75 arrangements"). Finally, new section 275A makes express for the NHS Act 2006 the assumption that a general reference in the Act to a person's functions is capable of covering functions delegated to the person.

Collaborative working

Clause 62 amends the NHS Act 2006 by removing the SoS and NHSE's duties to promote autonomy. This is to allow for the introduction of clause 37 which gives the SoS the ability to direct NHSE in regard to the exercise of their functions.

Clause 64 amends sections 72 and 82 of the NHS Act 2006 and section 96 of the 2012 Act. Section 72 of the NHS Act 2006 is a duty imposed on NHS bodies, including some Welsh NHS bodies, to co-operate with each other. Clause 64(2) inserts a new power into section 72 of the NHS Act 2006 for the SoS to make guidance on how this duty is discharged. It also imposes a duty on NHS bodies, except for Welsh NHS bodies, to have regard to this guidance. Section 82 of the NHS Act 2006 is a duty imposed on NHS bodies and local authorities (including Welsh NHS bodies and Welsh local authorities) to co-operate with one another in order to advance the health and welfare of the people of England and Wales. Clause 64 section (3) inserts a new power for the SoS to make guidance related to England, and imposes a duty on NHS bodies and local authorities, except for Welsh NHS bodies and Welsh local authorities, to have regard to this guidance.

Implications

Before discussing some of the implications arising from the Bill we need to define the meaning of 'accountability'. One definition sees accountability as a 'relationship between an actor and a forum, in which the actor has an obligation to explain and to justify his or her conduct, the forum can pose questions and pass judgement, and the actor may face consequences'. (Bovens, 2007, p.467). Accountability can be 'vertical' or 'horizontal' depending on whether the form of organisational co-ordination is a hierarchy or a network accordingly.

Vertical accountability refers to a hierarchical relationship through which achievement of predefined objectives is effected by conscious control of tasks, in which lower levels are

commanded by higher tiers in the hierarchy. Horizontal accountability is observed in 'network' forms of co-ordination and is realised through relationships, with individual organisations holding each other to account. (For a fuller discussion of accountability see Moran et al., 2021). The predominant structure of the NHS is that of a hierarchy. In the past few years (since the introduction of Sustainability and Transformation Partnerships (STPs)), however, the NHS has been moving increasingly to a combination of hierarchical and network relationships. The Bill is intended to put in place structures to facilitate integrated care, increase local autonomy and, at the same time, increase accountability. These intentions are presented as being necessary to improve provision of healthcare services, but it will be difficult to reconcile in practice. Integrated care is likely to result in blurred lines of accountability and there is the potential for conflict between achieving greater local autonomy and increased accountability.

In the new Bill, the main lines of vertical accountability will run downwards from the SoS (who is directly accountable to parliament), to NHSE (who will be directly accountable to the SoS), and NHS commissioners and providers (who will be directly accountable to NHSE). At the same time, there will be introduced a number of 'network' type structures (e.g. co-operation at place level, ICPs, provider collaboratives), which, in addition to being vertically accountable within the NHS hierarchy, will also be governed by horizontal lines of accountability.

Vertical accountability

As mentioned above, the Bill proposes to increase the SoS's powers of intervention, from giving directions to NHS England (e.g. delegate public health functions) and other ALB's, to intervening in local service reconfigurations. The government's argument is that, due to the intention to expand the powers and responsibilities of NHSE, 'the Bill seeks to introduce an additional accountability mechanism to support the SoS in their democratic oversight of NHSE'. Use of such powers, however, may result in loss of local autonomy. As reported in the *Health Services Journal (HSJ)*, many NHS leaders expressed anxiety over proposals to increase the SoS's powers of intervention. They see them as inappropriate interference by the DHSC in the NHS, and are asking for the proposals either to be dropped or for further clarification to be provided on the conditions under which such powers are to be used. ('First major NHS legislation in nine years confirms DHSC power grab', *HSJ*, 6 July 2021).

A further potential issue related to vertical accountability concerns the oversight NHSE is meant to exercise over integrated care systems (ICSs). At the ICS level of the NHS hierarchy, the lines of accountability become increasingly complex. ICSs will be themselves accountable to NHSE, and they will also be responsible for holding their member organisations and partners to account. In other words, the ICS will be vertically accountable to NHSE and horizontally accountable for the workings of the system as a whole.

The Bill does not explain how NHSE will be holding ICSs to account. One way is of course through the stipulated financial controls. It is, however, not clear what sanctions (if any) NHSE can impose on ICSs which fail to work within the annual financial envelope. Clarification of these issues has been provided in the recent publication of the 'NHS system oversight framework 2021/22'. This document repeats the intention to take a 'system wide approach'

when assessing performance. It also explains that NHSE will be adopting a grading approach when assessing performance of ICSs, Trusts, and CCGs (until their abolition). For systems, trusts and CCGs allocated to segment 4 (i.e. worst performance), a new national Recovery Support Programme (RSP) will be introduced, to replace the existing separate quality and finance special measures programmes. The overall approach of NHSE's response to weak performance is described in the document as 'mandated support'. In addition, the Bill gives NHSE the power to delegate to ICBs (Clause 7). This, in contrast to the intention of the Bill to increase local autonomy, may potentially restrict the autonomy of ICBs. Similarly, the Bill proposes to allow NHSE to impose financial controls on FTs (Clause 52). As we would expect, FTs are not happy with the proposed restrictions and their loss of autonomy in that respect.
Until further guidance is published, it is not clear what degree of autonomy will be given to local systems. The Bill stresses the intention to increase local autonomy, but this is not easy to achieve in a hierarchical structure. On one hand, commissioners and providers of healthcare services need to have substantial flexibility to adapt services to their local circumstances. On the other hand, local flexibility may conflict with the need to follow a range of national guidelines and directions issued centrally by either NHSE or the SoS. The Bill does not clarify how, when such conflicts arise, they are to be resolved. According to some commentators, 'it is encouraging to see this ambition [for local flexibility] expressed in NHSE/I's guidance, but we'll need to see how this follows through in practice. For trust leaders, a key enabler of collaboration is flexibility. However, there are increasing concerns about the NHS's tendency to centralise, which could lead to an overly prescriptive system architecture – despite everyone's best intentions.' (Miriam Deakin, 2021; see also, Alderwick, Gardner & Mays, 2021). Examples in which conflict may arise between the need for local flexibility and the need to maintain vertical accountability are, guidance related to achieving the 'triple aim' duty, or SoS intervention in major service reconfiguration. In the case of service reconfiguration, the Bill does not make clear what the precise role and power of the Independent Reconfiguration Panel (IRP) will be, in light of the new power of the SoS. The White Paper had announced that the IPR would be abolished, but the Bill explains that the IPR will be taking on an advisory function.

Horizontal accountability

The Bill is even less clear when it comes to issues relating to horizontal accountability. Examples of horizontal co-ordination are ICPs, provider collaboratives, and other organisational collaborations aiming at delivering integrated care. A study of the introduction of Sustainability and Transformation Partnerships (STPs) suggested that STPs would be more effective if horizontal accountability were complemented by hierarchical accountability. According to the authors of the study, the relatively weak accountability mechanisms of horizontal co-ordination (such as those observed in network organisational arrangements) are strengthened by their relationship with the hierarchy, since the hierarchy can exert more power, for example by applying sanctions, meaning that vertical accountability will always outweigh horizontal accountability. The key issue is 'to design accountability arrangements with an optimal blend of vertical and horizontal imperatives' (Moran et al., 2021). The authors

concluded that accountability in ICSs (the successors of STPs) would increase if these bodies were to become statutory bodies and if relationships in network arrangements were governed by 'alliance' contracts (Moran et al., 2021). Now that ICSs are becoming statutory bodies they will be subject to hierarchical controls (by NHSE and SoS), which means these bodies will become more accountable both upwards (NHSE and SoS) and downwards (the public).

One of the reasons networks have weak accountability mechanisms is that they have multiple forms of accountability (e.g. vertical within their individual organisations and horizontal towards the network partners), which may be incompatible or undermine each other. (Moran et al., 2021). Making ICSs statutory bodies does not overcome this problem, since many of its members (e.g. healthcare providers) will continue being independent statutory bodies with their own vertical accountabilities to observe. The Bill does not clarify how conflicts arising from incompatible accountabilities between individual providers and ICSs will be resolved.

The status of ICSs is not made clear in the Bill. Commentators and NHS participants are wondering what exactly ICSs will be. According to one commentator, 'where will the ICS land on the spectrum between a collective partnership that serves its members and an oversight body that manages its members? Taken together, the recently published policy documents risk describing ICSs as a separate entity to the providers and other partners comprising them. This language risks moving away from the spirit of genuine partnership between organisations towards an additional management tier. Trust leaders are asking: what is the ICS, if not a sum of its constituent parts?' (Miriam Deakin, 2021).

The question is important since it relates to the issue of accountability. Can an organisation be both a network and a hierarchy at the same time? Either way, given that providers are themselves independent statutory organisations, how will ICSs be able to hold them to account? ICSs will be responsible for ensuring that the system as a whole does not exceed its allocated annual budgets. This may involve taking decisions which are not advantageous to some of its constituent providers. It is not clear so far, how conflicts arising between the ICS and its constituent members are to be resolved.

Similar questions arise in relation to provider collaboratives (which are not mentioned in the Bill but are part of the policy agenda). What will be the relationship between ICSs and provider collaboratives? By what mechanisms will ICSs be holding provider collaboratives to account? One mechanism could be via contracting (e.g. 'alliance' contracts, 'lead provider' contracts), but it remains to be seen what mechanisms ICSs will put in place to deal with such questions. As one commentator put it, 'it is also essential that the creation of ICSs with statutory duties does not muddy the current clarity around trusts' accountabilities for the quality of care they deliver, and, as employers, for their staff. Trust leaders continue to question how accountabilities will operate in practice, without overlap or duplication between the ICS and trusts (Miriam Deakin, 2021).

Similar questions arise in relation to accountability arrangements of ICPs and 'place based partnerships'. Both of them are committees of ICBs but it is not clear how they are to be held accountable by the ICB. In other words, what levers will ICBs have in cases of failure to deliver

on the agreement either by an ICP or a place based partnership? For example, will ICBs be able to impose sanctions and, if so, what kind of sanctions?

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Appendix 1

SoS 'Henry VIII' powers

As mentioned above, the Bill contains a number of clauses that confer 'delegated powers', allowing the SoS to exercise significant control over the running of the NHS. The Bill contains a total of 138 powers, 7 of which include power to amend primary legislation through secondary legislation. The latter are all subject to the affirmative procedure. These "Henry VIII" powers are proposed in order to ensure that legislation continues to operate effectively and the statute book is kept up to date regularly. The Henry VIII powers in the Bill are contained in the following provisions: Clause 11, 85, 87, 88, 123, 130, and Schedule 16.

Clause 11 relates to secondments to NHSE.

Clause 85 relates to Medicine Information Systems (Clause 85(3) inserts a new section 7A which confers a delegated power on the SoS to make regulations providing for a system of information in relation to medicines to be established and operated by the Health and Social Care Information Centre ("the Information Centre"), and specifies the type of provision which can be included in the regulations.

Clause 87(1) confers a power on the SoS, through regulations, to transfer functions between the 'relevant bodies'. The relevant bodies are: Health Education England; The Health and Social Care Information Centre; The Health Research Authority; The Human Fertilisation and Embryology Authority; The Human Tissue Authority; NHS England.

Clause 88(1) confers a power on the Secretary of State to provide, through regulations, for a relevant body to exercise specified functions of the SoS on their behalf.

Clause 123 refers regulation of health care and associated professions. It amends section 60 and schedule 3 of the Health Act 1999 and enables further changes to be made through secondary legislation to the professional regulation system. This power extends to the regulation of social care workers in England, for whom the power to regulate in legislation is not currently enacted.

Clause 130 gives the SoS the power to amend, repeal, revoke or otherwise modify any provision within this Bill or any provision made by or under primary legislation passed or made either before this Act is passed or later in the same Parliamentary session. Where regulations modify primary legislation, the affirmative procedure must be used. Otherwise, the regulations can be made under the negative procedure. This provision may be used to amend primary legislation passed in any part of the United Kingdom.

Clause 131, subsection (2) clarifies that regulations under this Act are to be made by statutory instrument.

Schedule 16 refers to advertising of less healthy food and drink.