The King's Fund

Ideas that change health care

Briefing

Health and Care Bill: House of Lords second reading

Summary

- This legislation will remove clunky competition rules and make it simpler for health and care organisations to work together to deliver more joined-up care to the increasing number of people who rely on support from multiple different services.
- These reforms are complex and to help those who will implement them, the government should set out a clearer narrative as to how these changes will work in practice and make a positive difference to patients and service users.
- The legislation is designed to be permissive and flexible to local circumstance. We encourage parliament to resist specifying in legislation granular detail about how improved collaboration should be achieved, as this would risk undermining the local flexibility that is critical for delivering integrated care.
- Extensive new powers for the Secretary of State to intervene in local service reconfigurations bring the risk of a decision-making log jam and dragging national politicians into local decisions over services. We believe these clauses should be removed from the Bill or, at the very least, substantial safeguards added over their use.
- Parliament should seek further clarification about the scope of the new powers conferred on the Secretary of State by the Bill, in particular those to direct NHS England, and ensure that there is adequate scrutiny of their use.
- The measures in the Bill to address chronic staff shortages remain weak. A new duty should be added to the Bill, requiring the regular publication of projections of the current and future workforce required to deliver care to the population in England
- The Covid-19 pandemic has exposed deep and widening health inequalities. To ensure addressing this challenge is given sufficient priority, the new 'triple aim,' which is designed to create a common purpose across the NHS, should be amended to incorporate reducing health inequalities.
- The change to the social care cap is regressive and will mean that the main beneficiaries of the government's reforms will be people with higher assets, while the benefit to people with low to moderate assets will be marginal. To protect people with lower assets from catastrophic costs, the change to the care cap should be removed from the Bill.

Introduction

The Health and Care Bill (House of Lords Bill 2021–22) introduces new measures to promote and enable collaboration in health and care, building on earlier recommendations made by NHS England and NHS Improvement in 2019. The Bill also contains new powers for the Secretary of State to intervene in the health and care system, and targeted changes to public health, social care, and the oversight of quality and safety.

This briefing focuses on Parts 1 and 6 of the Bill, which deal with the NHS and its relationships to other parts of the system, including the powers of the Secretary of State, plus changes to the cap on social care costs.

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

Integration and collaboration

We strongly welcome the move away from the old legislative focus on competition as the driver of improvement in health and care towards a new model of collaboration and integration. We have long championed the need for integrated care to support the increasing number of people living with multiple conditions who rely on the support of many different services. The measures in this Bill will support greater collaboration between the NHS, local authorities, the voluntary and community sector and other partners with the aim of improving population health. Many of the proposals within this Bill were specifically requested by NHS leaders, are widely supported by stakeholders and build on existing work to integrate care.

While legislation can remove some barriers to collaboration, it is not possible to legislate for collaboration and co-ordination of local services. This requires changes to the behaviours, attitudes and relationships of staff and leaders right across the health and care system, including within national bodies. Therefore, implementation is critically important, especially as the legislation is complex and rightly leaves so much to local discretion. To support implementation, it is essential that there is a clearer narrative about the purpose of these reforms.

Alongside National Voices, Age UK, the Richmond Group of Charities and others we have produced a joint vision for what these reforms could achieve (National Voices *et al* 2021). In that vision, we argue that these reforms will be deemed a success if they enable organisations to work in partnership to address the wide range of factors that affect the health of their local communities; lead to more joined-up, co-ordinated care that meets individuals' needs in a flexible way; and ensure workforce planning and development meets future needs, while supporting the people working in health and care today. We believe this is a good starting point for a clearer narrative about the purpose of the reforms.

These reforms are important and complex and to help those who will implement them, the government should do more to articulate the vision behind them and

set out a clear narrative as to how they will work in practice and make a positive difference to patients and service users.

New structures

At the heart of the changes to support integration is the formalisation of integrated care systems (ICSs), which already exist in all parts of England, and which, under this legislation, will be placed on a statutory footing. Each ICS will be made up of two parts: an integrated care board (ICB) and an integrated care partnership (ICP). ICBs will be tasked with the commissioning and oversight of most NHS services and will be accountable to NHS England for NHS spending and performance. ICPs will bring together a wider range of partners to develop a plan to address the broader health, public health and social care needs of their local population.

Schedule 2 of the Bill states that the ICB membership must include, as a minimum, a chair (appointed by NHS England and approved by the Secretary of State), a chief executive, an NHS provider representative (nominated by local NHS trusts), a primary care representative (nominated by local GPs), and a local authority representative (nominated by local authorities). ICPs will be established by the ICB and its partner local authorities in the area but otherwise the membership and ways of working of ICPs has been left very flexible (Clause 21). We welcome this permissive approach as it gives areas the freedom to build on existing local relationships and partnerships.

Relationship between bodies

We believe ICSs should primarily look out to the needs of their local population, rather than looking up to the demands of national bodies. This shift in focus cannot be legislated for and underlines the importance of culture, behaviour and the careful implementation of these proposals.

There will be multiple plans and strategies in each ICS. At the more local 'place' level, there will be joint strategic needs assessments as well as health and wellbeing strategies (both produced by health and wellbeing boards which will remain in place), while at the ICS level, there will be an integrated care strategy (developed by the ICP) and a five-year forward plan (developed by the ICB and to be updated annually).

While this introduces a high level of complexity and risk of confusion, it must be remembered that the organisation and delivery of health and care services is itself complex with services varying from the very local to the fully national and with significant differences in the governance of the NHS and local authorities. Equally, the needs of local populations vary greatly, and it is important to give ICSs the freedom to respond to them. Imposing a one-size-fits-all architecture would remove these flexibilities and should be resisted. ICSs already vary greatly in size and population.

How well different bodies and their plans work in practice will depend on the quality of relationships and leadership in the area, the effectiveness of health and wellbeing boards, the clarity of vision/leadership locally and the support and time given to local areas to

develop stronger system working. This further emphasises the importance of implementation.

To help make sense of the proposed new structures, The King's Fund has produced a visual guide to how the new structures are intended to function (The King's Fund 2021).

The importance of partnership at the 'place' level

The White Paper that preceded this legislation (Department of Health and Social Care 2021) emphasised the primacy of joint working at the 'place' level, which is a smaller footprint than that of an ICS, often based on that of a local authority. We support this emphasis, as experience suggests that much of the heavy lifting of integration will be driven by organisations, including the voluntary and community sector, collaborating over smaller geographies within ICSs.

The White Paper emphasised the need for flexibility in these local, place-based joint-working arrangements. For this reason, the Bill does not include legislative requirements to collaborate at the level of 'place', but it does make clear that ICBs will be able to exercise their functions through place-based committees (Clause 62). This local drive for joining up services will be through place-based partnerships between commissioners and providers of services (including local government and the voluntary sector), and through provider collaboratives

We are pleased that the legislation avoids a one-size-fits-all approach to arrangements at place level. We support the permissive approach set out in the Bill that will allow places the freedom to respond to the needs of their local populations(Charles *et al* 2021). This does, however, make it all the more important for the government to set out clearly to Parliament how the reforms will work, given that important elements such as place-based working and provider collaboratives are only implicit in the legislation.

The government has sad that ICS are 'a necessary step in the right direction' but that they wish to 'go further to ensure that people using health and social care services experience well-coordinated care'. It is not yet clear how these proposals, when they emerge in a White Paper planned for next year, will connect to the structures to support integration as set out in the Bill.

Previous reforms have over-specified local arrangements, so we welcome the permissive and flexible approach set out in the Bill. It is important to avoid specifying in legislation granular detail about how improved collaboration should be achieved, particularly at the place and provider collaborative level, as this would risk undermining the local flexibility that is critical for integrated working.

Removing competition

A reduced focus on competition between providers is welcome. Health care in England has never been a truly competitive market and evidence for the benefits of competition is equivocal at best (*see* for example, Dixon and Spencelayh 2014). As we have seen

throughout the Covid-19 pandemic, collaboration between organisations is key to driving innovation and improvement.

One of the changes included in the Bill is the reduction in compulsory competitive procurement (Clause 74). The onerous competitive tendering regime introduced through the Health and Social Care Act 2012 has created barriers to integration, while adding to complexity and cost without delivering noticeable benefits for patients, so we welcome these changes. However, many areas – including non-clinical services – will remain within the scope of existing procurement processes. This will help to ensure appropriate checks and balances on the procurement of external services such as catering and management consultancy.

Some have raised concerns that this legislation will allow contracts to be awarded to new providers without sufficient scrutiny, opening the door to private providers. In fact, this is less likely under the new system, in which the NHS provider selection regime (NHS England and NHS Improvement 2021) allows for contracts to be rolled over where the existing provider is doing a good job, coupled with the duty on commissioners to act in the best interests of patients, taxpayers and their local populations.

Rather than contracts being awarded to new providers without sufficient scrutiny, we believe the greater risk is that contracts are automatically handed out to incumbent providers irrespective of their performance. While it is important to ensure that the provider selection regime does not prove onerous, there may be a case for giving the ICP some oversight role over the functioning of the provider selection regime.

Secretary of State powers to intervene in local service reconfigurations

As it stands, the Bill (Clause 40; Schedule 6) would give the Secretary of State sweeping powers to intervene earlier in decisions about changes to local services. Such broad powers create the risk of a decision-making log jam and dragging national politicians into local decisions over services.

The Bill would require the Secretary of State to be notified when an NHS body is aware of circumstances that it thinks are likely to result in the need for service change. The explanatory notes published alongside the Bill (House of Commons 2021, paragraph 103) say that the new powers would also allow the Secretary of State to 'be the catalyst for a reconfiguration where he thinks appropriate'. It is hard to imagine a situation where the Secretary of State would be the best catalyst for a reconfiguration. These decisions are best made locally, and this power would go against the commitment to maintain the clinical and operational independence of the NHS.

It remains unclear what scale or scope of service changes would require the NHS to notify the Secretary of State. The Health and Care Bill explanatory notes (House of Commons 2021, paragraph 92) state that the current system for reconfigurations will remain in place for 'day-to-day transactions', while service changes that are 'complex' will be referred to the Secretary of State, but the distinction between the two is unclear and is not explicit on the face of the Bill. Despite assurances from the Minister in the House of Commons that government does 'not anticipate that the power will need to be used on

many occasions', there is a high risk that a large number of service-change decisions landing on the Secretary of State's desk, risking a decision-making log jam and placing a significant burden on local and national bodies awaiting decisions. For reforms that are intended to reduce bureaucracy, this could create a significant new bureaucratic burden.

At Committee stage in the House of Commons, the Minister argued that these new powers are necessary to ensure democratic oversight of health service decisions. This argument ignores the fact that earlier involvement of the Secretary of State (or threat of earlier involvement) constitutes an erosion of NHS clinical and operational independence. It risks bringing political calculations into decisions that should be made based on patient need. There is an existing system for resolving any contentious service change decisions and this wholesale change is not justified.

To avoid the unhelpful politicisation of local service-change decisions and avert the risk of a decision-making log jam, we urge the government and parliament to remove from the Bill those clauses that would give the Secretary of State sweeping powers to intervene in local service reconfigurations, or at the very least, substantial safeguards added over their use.

Secretary of State powers to direct NHS England

The Bill recognises the work already undertaken to bring together NHS England and NHS Improvement into a single organisation and places it on a statutory footing by abolishing Monitor and the NHS Trust Development Authority (the two bodies that work together under the name NHS Improvement) and transferring their functions to NHS England (Clause 28, Clause 31).

In recognition of the increased range of functions this newly merged body will have, Clause 39 of the Bill includes measures to give the Secretary of State greater power to direct NHS England beyond the objectives set out in the government's NHS Mandate.

Since the 2012 reforms, the scope of NHS England's work has increased significantly, most recently with the announcement that Health Education England, NHSX and NHS Digital will also be folded into NHS England. It is also well recognised that the existing Mandate is not an effective vehicle for setting NHS England's objectives and holding it to account. This provides a rationale for making changes to the Mandate to increase its flexibility.

The Bill specifies some limits to how the new power of direction over NHS England could be used, but it is still very broad. Whilst we do not disagree about the need for a power of direction or appropriate powers to match the political responsibility of the Secretary of State for the health and care services (and the public expectations that comes with), we do not think this power should extend to intervening in NHS England's operational independence. Establishing NHS England at arms-length from ministers is one of the successes of the Health and Social Care Act 2012. To protect its operational and clinical independence, we believe more specificity should be provided on the scope of these powers; the circumstances in which they might be used and where they may not be used; what they add to the reformed Mandate and existing framework agreement between the

Department of Health and NHS England; and the oversight and scrutiny in place to review how they are used. We look forward to the views of the Delegated Powers and Regulatory Reform Committee on this.

We do not believe it would undermine the appropriate powers of the Secretary of State if it was made clear that this power cannot be used, for example, to intervene in procurement decisions, allocations to ICSs and other bodies. or to force NHS England to use its powers against individual NHS organisations. We believe this clarity would ensure enduring confidence that Ministers (including those in the future) would not be drawn into these decisions.

Parliament should seek further clarification regarding the scope of the new powers of the Secretary of State to direct NHS England, including how they might be used and what scrutiny of their use will be put in place.

Health and care workforce

The health and care workforce crisis will be the rate-limiting factor in tackling the care backlog and delivering the ambitions behind the reforms in this Bill. Years of poor planning, weak policy and fragmented responsibilities for the workforce mean that staff shortages have become endemic. Before the outbreak of Covid-19, chronic excessive workloads were commonplace and levels of stress, absenteeism and turnover were worryingly high (NHS England and NHS Improvement 2020a; Skills for Care 2020). Many staff will emerge from the pandemic physically and mentally exhausted and in need of time and support to recover.

The 2019 Conservative Party manifesto included pledges to deliver 50,000 more nurses, 6,000 GPs and 6,000 other primary care professionals. Two years on, no plan to address workforce shortages has been published, funding for the training and development of staff was conspicuous by its absence from the Spending Review and the measures in the Bill relating to workforce remain weak. The workforce crisis has become a blind spot for the government, with the Secretary of State recently admitting that the pledge to deliver 6,000 GPs is not on track (House of Commons Health and Social Care Committee 2021a).

Clause 35 of the Bill places a duty on the Secretary of State to report at least every five years on the system for assessing and meeting workforce needs. Alongside more than 70 organisations (Royal College of Physicians 2021), we have called for this requirement to be strengthened by mandating the regular publication of independently verified workforce projections. The Health and Social Care Committee has also recommended that the Bill include a requirement for objective, transparent and independent reporting on workforce shortages and future staffing requirements (House of Commons Health and Social Care Committee 2021b).

We supported a new clause, defeated at Report stage in the House of Commons, that would have required biannual publication of current and future workforce projections, based on the forecasts made by the Office for Budget Responsibility. In response, the Minister dismissed the need for such projections, pointing to a planned update to 'Framework 15', Health Education England's 15-year strategic framework for workforce

planning. This is inadequate – previous iterations of the framework (Health Education England 2017b) have not quantified the workforce numbers needed, and the Secretary of State was recently unable to confirm that the revised framework will set out the required numbers of staff (House of Commons Health and Social Care Committee 2021a).

The recent past is littered with promises of workforce strategies and frameworks that have either not materialised or have failed to deliver the action needed. An amendment to the Health and Care Bill requiring the publication of long-term workforce projections would provide the political impetus to finally get to grips with one of the most significant challenges facing health and care services.

The last comprehensive health care workforce strategy was published in 2003 and the need for a new strategy is now overwhelming. We urge parliament to support an amendment to Clause 35 that would mandate the publication of regular, independently verified projections of future demand and supply of the health and social care workforce in England.

Tackling health inequalities

The pandemic has exposed deep and widening health inequalities between different population groups and geographical areas. The life expectancy gap in England is now a growing chasm (Raleigh 2021) and disparities in access to care are starting to emerge, with people living in the most-deprived areas in England nearly twice (1.8 times) as likely to experience a wait of more than one year for hospital care than those who live in the least-deprived areas (Holmes and Jefferies 2021).

Despite individual commitments and pockets of success, the health system has failed to make progress in tackling health inequalities over the past decade because it has not been a high enough priority and has been trumped by other issues such as waiting times and financial targets. To address the widening health gap, reducing inequalities should be given a much higher priority in NHS decision-making, so that it moves from being a 'nice to have' to a 'must do' (Robertson *et al* 2021).

Clause 5 of the Bill introduces a new duty on NHS organisations to have regard to the 'triple aim' of ensuring better health and wellbeing, improving the quality of services and making efficient use of resources. The aim is not to burden NHS organisations with onerous reporting requirements but to provide a guiding light and align them behind a shared set of system-wide goals.

To ensure tackling health inequalities is given sufficient priority across the system, this duty should be amended to incorporate the need to reduce health inequalities within the triple aim. In the House of Commons, the Minister argued that duties on NHS organisations to pay attention to health inequalities are already included in existing legislation and that tackling health inequalities is covered in the triple aim as it is currently drafted by the inclusion of the requirement to promote health and wellbeing. Neither argument is convincing. As evidenced by the widening gulf in inequalities, existing legal requirements on NHS organisations have not proved strong enough, and omitting health

inequalities from the triple aim would repeat the mistake of the past decade by not making it an explicit priority.

The triple aim will be the guiding light for NHS organisations, providing a defining mission for them to unite behind. We therefore recommend that parliament amend the Bill to make addressing health inequalities a core aspect of the new duty.

Part 6: Miscellaneous

Cap on care costs

Clause 140 of the Bill amends the Care Act 2014 to fundamentally change the cap-and-floor model of social care funding enshrined in the Act. The change means that any local authority contribution towards paying for a person's care would no longer be counted towards the cap on their total costs. This significantly reduces protection against very high care costs for people with low to moderate assets and is likely to mean that many of them will still be forced to sell their homes to fund their care, while people with more assets from wealthier parts England will be protected from this.

Sir Andrew Dilnot considered this approach to the cap in 2011 and discounted it as unfair on the basis that it will result in people with low levels of wealth spending the largest proportion of their assets on care costs. Ministers have justified the change by saying that the new system will be more generous than the current one. While it is true that everyone will be better off under the reformed system – which is being funded through the increase in National Insurance embodied in the Health and Social Care Levy – the main beneficiaries will be people with higher assets, while the benefits for people with low to moderate assets will be marginal.

The change to the social care cap is regressive and runs counter to the government's ambition of 'levelling up'. To ensure those people with low to moderate assets are protected from catastrophic costs, the clause 140 change to the care cap should be removed from the Bill.

Cross-cutting issues

Timing of the legislation

This Bill comes at a time when the NHS, local authorities and voluntary and community sector organisations are still dealing with Covid-19 and its impacts. The move to ICSs will mean a lot of change for commissioning bodies and their staff, with clinical commissioning groups coming to an end and their functions being folded into new bodies.

However, unlike previous NHS reorganisations, many of these reforms build on existing work in many areas, and much of the legislation was requested by health and care leaders themselves. This Bill is not the starting pistol for a wholesale shift in focus. Instead, it aims to refine the legislative framework to better support the ongoing drive towards more

joined-up care set out in the NHS Five Year Forward View (NHS England 2014) and NHS Long Term Plan (NHS England and NHS Improvement 2019b).

The legislative timetable does pose some challenges for implementation of these reforms. The government has set the expectation that these reforms will receive Royal Assent in time to be implemented from April 2022. This creates a tension between the health and care system's need for clarity in order to plan services, and the need to allow sufficient time for parliamentary scrutiny of the Bill. Changing the implementation timetable at short notice could be very disruptive for health and care services so the government should consider now whether the April 2022 ambition is realistic, and, if it is unlikely to be met, act swiftly to set a more feasible implementation date.

Shifting power as a consequence of the legislation

Throughout the Bill, there is a tendency towards creating broad enabling powers for the Secretary of State, for example, over arm's length bodies. The government has suggested that these are needed to enable the Secretary of State to respond more flexibly to rapidly changing circumstances, such as those seen during the pandemic. However, the legislation and accompanying explanatory notes do not make clear why such powers would be needed outside of a pandemic, nor why reducing parliamentary scrutiny in this way is merited.

These proposals represent a significant shift from primary to secondary legislation, with more power being moved from previously independent arm's length bodies to the Secretary of State while at the same time, reducing parliamentary scrutiny. We look forward to the views of the Delegated Powers and Regulatory Reform Committee on this.

Parliament should consider whether stronger measures are needed for parliament and others to scrutinise the use of the new powers conferred on the Secretary of State by this Bill.

Health and care system reform in totality

While the Bill includes some limited, targeted changes to public health and social care, the proposals predominantly amount to reforms of the NHS – with a focus on integrating services, collaborating more effectively with other partners, and the relative balance of power between national players.

The NHS does not work in isolation – public health, social care and the NHS are closely connected. Since this Bill was first published, the government has implemented significant reforms to the public health system, published a White Paper on social care, promised 'fundamental and far-reaching reforms' covering technology and innovation and announced a review of leadership in the NHS and social care. Further White Papers on integrating health and social care and prevention and health inequalities are expected next year (Cabinet Office *et al* 2021).

Amid these multiple, separate initiatives, there is a need for clarity about how the various reforms will work together. Such clarity would help position this Bill within the wider

picture and ensure that the largely NHS-focused reforms it contains do not inadvertently limit positive change in public health, social care and other areas.

Conclusion

The King's Fund supports the main thrust of the Health and Care Bill which will remove clunky competition rules and enable greater collaboration between health and care organisations to deliver integrated care. We also support the permissive approach that will allow local areas to decide how they best work together to meet the needs of their communities.

However, there are aspects of the Bill that we believe should be changed. Most notably, the regressive change to the cap on social care costs should be removed from the Bill. The new powers for the Secretary of State to intervene in decisions about service reconfigurations should also be removed or, at the very least, substantial safeguards about their use should be added to the Bill.

We strongly believe the Bill should be amended to require the regular publication of health and care workforce projections to enable a more strategic approach to meeting health and care staffing needs. Finally, the proposed 'triple aim', intended to be the guiding light for health services, should be amended so that tackling deep and widening health inequalities becomes 'mission critical' for the NHS.

About The King's Fund

The King's Fund is an independent charity working to improve health and care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible health and care is available to all.

Contact

Andrew McCracken
Head of Press and Public Affairs
The King's Fund

a.mccracken@kingsfund.org.uk
+44 (0)7774 907 960

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