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The Health and Care Bill 2021

House of Commons, Second Reading, 14 July 2021

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS trusts and foundation trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has all trusts in voluntary membership, collectively accounting for £92bn of annual expenditure and employing more than one million staff.

Overview of the Health and Care Bill

The publication of the Health and Care Bill (the Bill) follows a set of proposals for legislative change originally brought forward by NHS England and NHS Improvement (NHSE/I) in autumn 2019. These were further developed in the *Integrating Care* consultation with regard to system working and, most recently, in the Department of Health and Social Care's (DHSC's) *Integration and Innovation* white paper published in February this year.

The majority of the Bill is focused on developing system working, with integrated care systems (ICSs) being put on a statutory footing. It also formally merges NHS England and NHS Improvement, and gives the secretary of state a range of powers of direction over the national NHS bodies and local systems and trusts. Other measures proposed include putting the Healthcare Safety Investigation Branch (HSIB) on a statutory footing; a new legal power to make payments directly to social care providers; the development of a new procurement regime for the NHS; and a new duty on the secretary of state to report on workforce responsibilities. A comprehensive summary of key parts of the Bill as well as NHS Providers' view on those provisions can be found here.

The government has stated that the Bill will allow it to build and shape a health system that is better able to serve the people of England in a fast-changing world. Its intention is to create a system that is more accountable and responsive to the people that work in it and the people that use it. We support this direction of travel and the opportunity the Bill presents to design the right system architecture

that will deliver sustainable high-quality care for the future. We believe there are improvements that can be made which will make this the transformative piece of legislation the government wants it to be.

Key provisions in the Health and Care Bill

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

- The Bill includes provisions which cumulatively amount to far-reaching powers for the secretary of state. This includes powers of direction over NHS England and the ability to intervene at any stage in local service reconfigurations. These measures are of particular concern to NHS Providers, as for other stakeholders across the sector. We are keen to maintain the NHS' clinical and operational independence and avoid the risk of political interference in the provision of services and will therefore seek appropriate safeguards to balance these powers.

- The Bill gives NHS England the power to set capital spending limits for foundation trusts. We will be seeking to amend the current proposals by asking parliament to consider adding safeguards which were previously agreed between NHS Providers and NHSE/I in 2019.

- We welcome a new duty on the secretary of state to set out how workforce planning responsibilities are to be discharged but believe that an additional duty should be added to the Bill to ensure the development of regular, public, annually updated, long-term workforce projections. There should also be a duty to regularly update Parliament on the government's strategy to deliver those long-term projections, including its approach to providing the required funding.

- The Bill also includes a number of changes to local financial arrangements. This includes setting requirements to meet financial objectives and balance, with NHS England having the ability to set additional and mandatory financial objectives specifically for NHS trusts. While we support greater integration within health services and across health and care, in the event that local organisations, or ICSs believe they have been set an unworkable financial envelope, or an impossible task within the resources available,it is important that the legislation also establishes clear routes for recourse.

- We strongly support putting the Health Service Safety Investigations Body (HSSIB) on a statutory footing and setting out the framework for its conduct of safe space investigations so that the NHS can improve patient care and learn from when things go wrong. Nevertheless, we are keen to ensure that the Bill provisions genuinely enable the HSSIB's independence, which is crucial to its ability to carry out its intended systemic safety role, as well as protecting the integrity of safe space.

- As the country emerges from the pandemic, the NHS continues to face considerable challenges including in direct response to COVID-19; the backlog of care and restoration of elective care; persistent and severe pressures on the workforce; and the impact of prolonged under-investment. The impact of amending the legislative framework within which the NHS operates and the NHS Providers additional burden this will create for the NHS and its staff should not be underestimated at this time.

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

Areas of concern for NHS Providers

We fully support the government's ambition to build and shape a health system that is better able to serve the people of England. Creating a system that is more accountable and responsive to the people that work in it and service users is key. We support those aims and will support a Bill that puts in place the right system architecture that will allow trusts to deliver sustainable high-quality care for the future. However, there are a number of areas where we want to see the Bill improved and additional safeguards put in place to protect the clinical and operational independence of the NHS.

1. The NHS' clinical and operational independence

Alongside the newly merged NHS England, a number of broad powers for the secretary of state are contained in the Bill. We are concerned that these powers, without proportionate safeguards, may undermine the NHS' clinical and operational independence.

Clinical and operational independence must be maintained in order to ensure equity for patients within the service; the best use of constrained funding; and clinical leadership with regard to prioritisation and patient care. While the intention may be to deploy these powers on rare occasions the potential impact is so great that we strongly believe that safeguards must be put in place. We

welcome the decision to add a duty to publish a direction but believe additional safeguards are needed to protect the NHS's independence by defining the power in terms of:

1. The publication of guidance defining an objective "public interest" test, its scope and the areas of decision making and activity where it might apply and, conversely, not apply. As drafted, the language is subjective and unclear. In line with the use of this test in other regulatory settings, there should be clear, proportionate and necessary criteria before the power is exercised.
2. The need for full and timely transparency when the power is exercised – we believe this should include the need for the secretary of state to set out why their use of the power of direction, on each occasion, meets an objectively defined public interest test before giving a direction.
3. The need for appropriate consultation with affected parties before the power is exercised including, as part of the transparency arrangements, the publication of the views of the body being directed.

Currently NHS England, Monitor and the Trust Development Authority (TDA) each have a different statutory base with varying degrees of ministerial power of direction. We think it is important that the newly merged organisation has an appropriate degree of independence and this needs to include the arrangements for its mandate.

We recognise the logic of the secretary of state having powers to move responsibilities between arm's-length bodies via secondary legislation. However, the exercise of these powers must not threaten the operational independence of key parts of the NHS. Of particular note is the power which would allow the secretary of state to transfer functions between bodies. The power to abolish a body such as the Human Fertilisation and Embryology Authority, or the power to transfer the majority of its powers to other bodies, requires proper parliamentary scrutiny. We believe that such moves should require primary legislation.

2. Safeguards around local reconfigurations

The Bill gives wide-ranging powers to the secretary of state to direct local service reconfigurations, with few (if any) safeguards. We fully support the secretary of state's leadership, and accountability for setting the direction of travel for the sector. However these proposals risk embroiling any secretary of state in decisions on local service reconfiguration which are best taken locally by the organisations that are accountable for those services following meaningful engagement with local communities. The clinical case for reconfiguration can sometimes be difficult to convey to the public, and a disproportionate escalation of plans to a national level risks politicising the situation and discouraging service improvements, such as integration, otherwise supported by the Bill.

While speed can be welcome in making reconfiguration decisions, this should not be at the expense of local ownership, engagement and decision-making. Local services spend considerable time developing reconfiguration plans, and do not do so lightly – they require leadership bandwidth, commitment and investment, as well as sensitivity to the current and future needs and preferences of local communities.

Our core concern is that the proposals do not sufficiently protect the best interests of patients. There is a risk to local accountability in the NHS, and with regard to local authority overview and scrutiny committees, and the balance would be tipped unsustainably and inappropriately towards political interference in the provision of local NHS services. We would suggest that the following safeguards are added:

1. That any secretary of state involvement should be fully transparent, with the right of the affected parties to make appropriate representation and the secretary of state's intervention made against set, public, criteria;
2. That there is an appropriate role for an independent body – akin to the Independent Reconfiguration Panel – to provide independent advice on detailed issues including the validity and importance of the clinical case for change;
3. That there should be an appropriate threshold governing the level of reconfiguration where the secretary of state is notified or involved;
4. That, given the overwhelming importance of patient safety in these considerations, there should be an explicit test that use of the power must maintain or improve safety before the power can be exercised; and
5. That, as part of the exercise of the power, the individual provider(s) and integrated care system (ICS) concerned, NHS England, and the public should all be consulted on the relevant safety issues before the power can be exercised, with those views then made public.

3. Integrated Care Boards: a permissive, enabling framework, and clarity around accountabilities across health and care

It is important that the Bill is enabling and permissive, in order to allow different systems to flexibly frame arrangements that best suit their local needs. We believe that this can be achieved by defining integrated care boards (ICBs) accountabilities in three ways: firstly, to Parliament, via the Department of Health and Social Care and NHS England; secondly, to local communities; and thirdly, to their component organisations. At the moment, accountabilities are framed around only the first of these, but expanding those to whom ICBs must look will better ground them in their communities and keep focus on serving patients.

Moreover, while we support the move to place ICBs on a statutory footing, we have significant concerns about how the relationships of local bodies fit together and align. We are also concerned about a lack of clarity in the legal duties, roles and responsibilities across the health and care system, including those of NHS England and the secretary of state. Given the nature and degree of power over systems and individual organisations that could be exerted under the Bill's proposals, it is essential to address this. Otherwise there is a risk of unclear accountabilities, confusion, stasis, duplication – and ultimately the potential for costly and time consuming judicial review proceedings.

The relationship between trusts and ICBs, and how the statutory accountabilities of trusts, foundation trusts and ICBs align, will be key to make crystal clear. There also needs to be clarity within the legislation on how the roles and responsibilities of the current NHSE/I regions, ICBs, integrated care partnerships (ICPs), trusts, foundation trusts, health and wellbeing boards (HWBs), places, provider collaboratives, and neighbourhoods/primary care networks (PCNs) will all fit together. To address this, we believe that the Bill should include the following:

1. A requirement to involve all partners in developing the ICB composition, constitution and plans;
2. Provision for a challenge mechanism for trusts to raise concerns to NHS England about the ICB composition, constitution and plans if necessary;
3. A requirement on NHS England to issue statutory guidance which states that each ICB must establish a mechanism which enables the views of all trusts to be heard as part of the ICB decision-making process;
4. Safeguards around the power for NHS England to intervene directly in how ICBs exercise their functions, in particular setting out how ICB failure, or being at risk of failure, will be defined, assessed and determined; and
5. Clarity on how organisations will discharge their legal duties where there is potential for overlap (for example, ICBs will have a role in quality improvement – how does this align with the role of providers here?).

4. NHS foundation trusts' capital spending limits

The Bill puts forward clause which gives a new power to NHS England to restrict the spending of any individual NHS foundation trust in the same way that expenditure by an NHS trust can already be limited. The power is not intended to be a general power used to set capital expenditure limits for all foundation trusts, nor direct a financial trust in relation to individual capital investment decisions. This proposal arises from the need for the Department of Health and Social Care (DHSC) and NHS England to ensure that the national capital expenditure limit cannot be breached.

However, we must be mindful that this proposal does not address the root cause of the problem at hand which is prolonged underinvestment in the NHS estate and technologies, and the need for a national capital expenditure limit that fairly reflects the NHS' investment needs. Despite recent welcome injections of funding, the capital maintenance backlog now stands at £9bn. Over half of this is considered a 'high' or 'significant' risk to patients and staff. NHS Providers is therefore continuing to call for recent increases to the NHS' capital budget to be sustained in future years and be distributed fairly across the provider sector. Ultimately, a limit on foundation trusts' capital expenditure is not going to improve patient safety, operational performance, efficiency nor the services' ability to transform and modernise care.

While we recognise the need, in the move to system working and given the overall national constraints on capital spending, for NHS England to have a reserve, backstop, power to set individual foundation trusts capital spending limits, it is vital that use of any such power foundation trust capital investment is carefully controlled. It is absolutely right that foundation trusts and trusts retain their current accountability for the delivery of safe care and having sufficient freedom over capital expenditure is central to this task.

We therefore have significant concerns on the proposed clause. The current drafting does not mirror NHS England and NHS Improvement's (NHSE/I's) September 2019 legislative proposal which was the result of detailed negotiations with NHS Providers on behalf of our foundation trust members. This clause also cuts across the Health and Social Care Committee's unequivocal position that the power to set capital spending limits for foundation trusts "should be used only as a last resort".[1] NHS England's 2019 legislative proposals contained a series of detailed safeguards that we consider essential to see in the Bill. These are:

1. The power to set capital spending limits for foundation trusts is circumscribed on the face of the Bill as a narrow reserve power;
2. Each use of the power should apply to a single named foundation trusts individually;
3. Each foundation trust's capital spending limit should automatically cease at the end of the current financial year;
4. NHSE/I is required to explain why use of the power was necessary, describing what steps it has taken to avoid requiring its use and include the response of the foundation trust when publishing each order; and

[1] Health and Social Care Committee, *NHS long-term plan: legislative proposals* (https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/2000/2000.pdf), 18 June 2019.

5 There is a requirement for each order to be published in parliament, to ensure maximum transparency

While we understand that accompanying guidance will be published outlining the circumstances under which NHS England is likely to make an order, and the method it will use to determine the capital spending limit, this is no substitute for including adequate protections in the Bill.

5. Financial objectives and routes of recourse regarding allocations

The Bill proposes that each ICB, and its partner trusts and foundation trusts, will be collectively required to deliver financial balance and seek to achieve financial objectives set by NHS England. A separate power would allow NHS England to set additional and mandatory financial objectives specifically for trusts. This builds on the existing duties placed on clinical commissioning groups and trusts under the Health and Social Care Act 2012 and NHS Act 2006 respectively.

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

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

While we expect the new financial regime to run smoothly the majority of the time, it is possible to foresee occasions when an ICB, trust or foundation trust believes it has been given an impossible task – for example, if it is concerned that its funding envelope is insufficient to meet patients' needs, potentially putting outcomes, quality of care and patient safety at risk. It is therefore important that clear routes to recourse exist. There is also a risk that funding could be diverted to supporting inefficient services rather than rewarding the most innovative and high performing providers.

Under the current financial regime, important checks and balances are enshrined in law. The Bill proposes a series of changes to financial flows (contract and payment mechanisms) that appear to symbolise a cumulative loss of independent oversight, including:

- The replacement of the national tariff with a new NHS payment scheme, representing a move away from mandatory national prices for many services to commissioners having more flexibility over the prices they pay providers;
- The formal merger of NHS England and NHS Improvement, meaning there will no longer be a process of negotiation embedded in the development of the NHS payment scheme; and
- The removal of an independent review mechanism to deal with objections to the NHS payment scheme, currently delivered by the Competition and Markets Authority as part of the existing statutory objection process for the national tariff.

It does not call into question the commitment of any of an ICB's partners to recognise that legislation needs to make provision for those difficult situations which, at times, will be unavoidable as much as partners may regret this.

The purpose of legislation is, at times, to safeguard against the extreme. As such, we will continue to work with DHSC and NHS England to explore what a reasonable system of checks and balances might look like. We want to ensure that if and when tensions arise, they can be resolved quickly, fairly and transparently.

Furthermore, we want the government to give careful consideration to the conditions needed to enable ICBs, and their partner trusts and foundation trusts, to collectively deliver financial balance. This will require an open and honest conversation ahead of the Comprehensive Spending Review about the funding needed to fully recover from COVID-19, transform the NHS, and build greater resilience into the wider health and care system.

6. Workforce accountabilities

While we welcome the duty contained in clause 33 on the secretary of state to set out how workforce planning responsibilities are to be discharged, we believe this duty needs to be considerably strengthened. The NHS is desperately lacking a regularly produced, long-term, workforce numbers plan setting out the desired future shape and size of the NHS workforce.

We believe that additional duties should be added to the Bill as follows:

1 To ensure the development of regular, public, annually updated, long term workforce projections drawing on input from all relevant NHS arm's-length bodies, NHS frontline organisations such as ICBs and trusts, and expert bodies such as think tanks. We believe these projections should set out, on an arm's-length basis, the size and shape of the future workforce needed to deliver safe, effective, high-quality care and the estimated cost of delivering this workforce

2 There should then be a duty on the secretary of state to regularly update parliament on the government's strategy to deliver those long-term projections, including its approach to providing the required funding.

3 We would also like to add a new statutory duty to involve local systems and trusts in workforce planning, as the current proposal to abolish local education and training boards removes this important statutory obligation on Health Education England.

7. The Health Services Safety Investigation Body

NHS Providers strongly supports the principle of creating the Health Services Safety Investigations Body (HSSIB) as an independent statutory entity and enabling it to conduct safe space investigations so that the NHS can improve patient care and learn from when things go wrong. We are concerned to ensure that the Bill provisions genuinely enable the HSSIB's independence – crucial to its ability to carry out its intended systemic safety role – and protect the integrity of safe space.

The parliamentary joint committee on the Draft Health Service Safety Investigations Bill in 2018 made clear the importance of the HSSIB's independence of judgement in deciding what investigations it undertakes. While we note that a direction "may provide for a person to exercise discretion in dealing with any matter", this does not seem to be a sufficiently strong safeguard. If the secretary of state is to be able to direct the HSSIB to carry out an investigation, then three explicit balancing provisions are needed to maintain the HSSIB's independence. Firstly, it must be able to decline to carry out the investigation where there is reasonable justification. Secondly, adequate funding must be made available to the HSSIB to enable it to carry out such investigations in order to avoid compromising its ability to carry out its investigative function as the HSSIB would otherwise determine. Thirdly, the continuing independence of the HSSIB in how it carries out any such investigation and the independence of its consequent recommendations is paramount and should be explicitly protected.

We are also concerned that the exceptions on prohibition of disclosure of protected materials are wide ranging, discretionary and unreasonably open to external applications for access. For example, the impact assessment published for the previous HSSI Bill in 2019 noted that, "Litigation in healthcare is a more frequent occurrence than in other areas of accident investigation. It is therefore possible that lawyers representing patients or NHS staff involved in safety incidents that have been investigated by HSSIB, may make applications for disclosure of 'safe space' information hoping to uncover material of benefit to their clients".[2] The High Court's balancing test seems liable to support

[2] Department of Health and Social Care, *Health Service Safety Investigations Body (HSSIB) Impact Assessment No 3136* (https://publications.parliament.uk/pa/bills/lbill/2019-2020/0004/20004-IA.pdf), 16 October 2019.

considerations of legal justice over those of systemic patient safety and learning, not least as the ability of the High Court to consider disclosure as potentially deterring information provision is questionable given that the HSSIB has powers to compel interviews and information provisions. With multiple avenues of information and powers of investigation – as well as the HSSIB's final reports being available – other bodies do not need access to protected material simply because of the HSSIB's existence. We recommend that the Bill be amended to put beyond any possible doubt that the 'safe space' cannot be compromised save in the most exceptional circumstances, and therefore that the prohibition on disclosure applies equally to disclosure to coroners.

Further, there needs to be clarification as to how the government expects these provisions to work, for example where disclosure may take place and the level of where the bar is set in considering disclosure. We believe that there needs to be a tighter drawing of the boundaries of safe space to ensure its appropriate preservation and in turn support participants in playing their full role in an investigation. We think that the tests for an application to disclose protected materials must be sufficiently strong to ensure that disclosure is only sought in extremis, that there is a clear and overriding public interest in any disclosure, that the anonymity, safety and privacy of participants is respected without exception, and that current and future investigations are not jeopardised.

8. Hospital food standards

We support the ambition to make food in hospitals safer, healthier and more sustainable, as it is an important factor in patient recovery and wellbeing. We are concerned to ensure that requirements here are workable and so would ask that a duty is included in the Bill for the secretary of state to formally and properly consult those who would have to implement the standards before they are set.

Trusts are already working hard to ensure they provide good quality food that meets nutritional standards. Arrangements for catering within trusts vary. Some do not have the kitchen facilities to be able cater on site for patients, and instead have links with national wholesale suppliers. Elsewhere, trusts have been able to develop close links with local suppliers, while others have been able to maintain their own kitchens. These differences will have an impact on how quickly, and at what cost, individual trusts will be able to comply with any new requirements. Potential cost implications could include investment in additional workforce and facilities. There would also be costs associated with renegotiating or winding down contracts and arrangements with suppliers/outsourced caterers. We believe full and proper consultation with trusts here will help the Department to map the issues and costs and avoid an unrealistic ask being set.

Conclusion

We welcome the publication of the Health and Care Bill, which we believe will help provide clarity for trusts in a fast-changing health and care landscape. Trusts have been at the forefront of the move towards closer collaboration and integration between health and care, a process that has accelerated in recent months to deal with the extraordinary pressures of the pandemic and we hope that the Bill will formalise this process, so trusts and their partners can plan and cooperate more closely to help build healthier communities.

However, there are key areas of concern for our members which will need to be resolved as the Bill goes through Parliament. Preserving the operational and clinical independence of the NHS so any new powers of direction for ministers do not impinge on issues such as procurement, treatment, drug funding and the hiring and firing of frontline NHS leaders is vital. It is also important to ensure ministers have appropriate powers in decisions over how local services are configured and that changes which improve quality and safety are not inappropriately blocked.

We welcome the move to place ICSs on a statutory footing but we have significant concerns about some of the detail in the Bill, particularly on the relationship between trusts and ICBs, and how the statutory accountabilities of trusts, foundation trusts and ICBs align. Ensuring ICBs develop to meet local needs rather than be pushed into a one-size-fits-all approach is key. We will continue to argue for a careful balance in how new potential controls on capital spending may be applied to foundation trusts in local systems. We will also continue to push for provisions which address the lack of a transparent, costed and funded long term workforce plan.

We look forward to working with MPs as this important piece of legislation progresses through Parliament.