The Health and Care Bill 2021

House of Commons, Report stage, 22 & 23 November

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.

The majority of the Health and Care Bill (the Bill) is focused on developing system working, with integrated care systems being put on a statutory footing. It also formally merges NHS England and NHS Improvement (NHSE/I), as well as making changes relating to public health, social care and patient safety.

We support the opportunity the Bill presents to design the right system architecture that will deliver sustainable high-quality care for the future. However, we also believe there are improvements that can be made which will make this the transformative piece of legislation the government wants it to be. Our briefing below provides commentary on amendments tabled for the Report stage in the House of Commons. NHS Providers' written evidence to the Commons Committee and analysis of amendments debated in Committee can be found here.

Key points

- We welcome the direction of travel set out in the Bill which aims to drive closer collaboration and integration across the health and social care sector, helping trusts to build healthier communities.
- While we welcome the move to system working, more clarity on how different parts of the health system will work together is needed. Allowing different systems flexibility in how they frame their arrangements to meet local needs will also be key.
- We are concerned that provisions in the Bill open up the possibility of political interference in the health service by drawing significant powers of intervention and direction to the secretary of state. Maintaining the clinical and operational independence of the NHS is vital to ensuring this complex system can work effectively.

- Similarly, we are concerned that new powers to allow the secretary of state to intervene in local service reconfigurations, as currently drafted, risk undermining local accountability in the NHS.
- We welcome measures in the Bill to place a new duty on the secretary of state setting out how workforce planning responsibilities are to be discharged but believe this duty needs to be strengthened.
- We strongly support the creation of the Health Services Safety Investigations Body (HSSIB) as an independent statutory entity. However, we are concerned with aspects of the Bill as currently drafted are liable to weaken the boundaries of safe space and the independence of HSSIB.
- We are keen to ensure that the new provisions that will give the Care Quality Commission (CQC) scope to assess and rate systems do not impact on its ability to provide independent assurance – in particular, the secretary of state's powers to set priorities and objectives for the CQC's assessments of integrated care boards (ICBs). The existing arrangements, which require CQC to consult the secretary of state, have been successful in providing the necessary assurance so we do not feel there is a need to change what already works well.

Amendments covered in this briefing

Part 1: Clauses 1 – 11 (NHS England)

- New clause 19

Part 1: Clauses 12 – 14 (Integrated Care Boards) and Schedule 2 (Integrated care boards: constitution etc)

- Amendment 25
- Amendment 26
- Amendment 27
- Amendment 28
- Amendment 76

Part 1: Clauses 15 – 19 (Integrated care boards: functions)

- Amendment 92
- Amendment 51

Part 1: Clauses 21 – 25 (Integrated care systems: financial controls)

- Amendment 69
- Amendment 114

Part 1: Clauses 34 – 39 (Secretary of State Functions)

- Amendment 10
- Amendment 70

Part 1: Clauses 75 – 80 (Miscellaneous)

- Amendment 60

Part 4: Clauses 95-121 (The Health Services Safety Investigations Body)

- Amendment 40
- Amendment 41
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NHS Providers' analysis

Clauses 1-11 (NHS England)

New Clause 19 (Clause 3)

Member's explanatory statement

This new clause would require the secretary of state to set objectives for the NHS on cancer treatment which are defined by outcomes (such as one-year or five-year survival rates), and would give those objectives priority over any other objectives relating to cancer treatment (such as waiting times).

NHS Providers' view

Given the prevalence of cancer across England and its devastating impact on patients and families, adequate access to prompt, safe and effective treatment is fundamental. We understand the benefit of benchmarking cancer outcomes and survival rates in the UK against comparable countries. This is important information which should inform policy decisions on cancer care, funding and workforce issues.

NHS England has already committed to improving how waiting times are calculated and improving performance measures to ensure they drive improvements for patients. In its Clinically-led Review of

NHS Access Standards, NHS England proposes a shift to a new Faster Diagnosis Standard, with a cancer diagnosis within 28 days of an urgent referral from an NHS screening programme or their GP, replacing the current 14-day window in which patients may see a specialist with no timeline in place to receive their diagnosis. This reflects the performance priorities clinicians have identified for cancer care, ultimately aimed at improving patient experience and outcomes. Trusts are currently in the process of moving towards the Faster Diagnosis Standard.

While we agree that outcome measures and survival rates must inform policy and practice in the NHS, the tabled amendment would emphasise outcomes over others, including waiting times. Given that the clinical review of standards is relatively recent and gained broad support across the sector, in our view, its proposals should not be diverted or complicated with additional measures at this stage.

Clauses 12-14 (Integrated Care Boards) and Schedule 2 (Integrated care boards: constitution etc)

Amendment 25 (Schedule 2)

Member's explanatory statement

This amendment prevents the appointment of a member of an integrated care board if they could reasonably be regarded as undermining the independence of the NHS because of their involvement in the private healthcare sector or otherwise.

NHS Providers' view

The Bill in its current form requires ICBs to include at least one partner member from trusts, primary care and local authorities alongside a chair, chief executive, finance director, medical director, nursing director and two independent non-executive directors. ICBs can appoint additional members to the board beyond the minimum requirements set out in the Bill and accompanying integrated care system (ICS) implementation guidance. The ICB chair effectively has a veto on all appointments.

As a unitary board, each ICB board member will be involved in allocating NHS funding to providers (or collaboratives/partnerships) within the local ICS. The premise behind this board composition is to ensure providers are involved in deciding who delivers services, thereby reducing the provider-commissioner split (albeit only to a certain extent). The Bill also revokes existing procurement and competition requirements, paving the way for the new provider selection regime that moves away from competitive retendering by default in favour of a more collaborative approach to planning and delivering services.

Private companies have always played a role in the provision of health services. Although the number of contracts awarded to private providers increased after the Health and Social Care Act 2012 extended market-based approaches and retendering, those contracts tended to be smaller than those awarded to NHS providers. There was therefore no significant increase in the share of the NHS' total revenue budget going to private providers, which has stayed relatively stable at around 7%. NHS trust leaders are clear that private providers are an important partner in local health and care systems, not least contributing to the pandemic response and recovery by providing additional capacity. They are also a key delivery partner in some mental health provider collaboratives.

It is also important to note that ICBs will have a unitary board comprising individuals (who are not representative of their sector), not private companies, public bodies or any other form of organisation. We would therefore query the meaning of the statement that private providers will not be given a seat at the table on ICBs. Additionally, ICBs will already need to effectively manage potential conflicts of interests when awarding contracts, given at least one trust will sit on the ICB. We will need clarity on the exactly how the amendment will be worded to prevent private companies being represented.

We understand the amendment will place the onus on ICB chairs to consider, during the appointment process for ICB boards, whether a candidate's involvement with the private sector could be seen as undermining the independence of the NHS. We would welcome assurances on the floor of the House that:

- This will not prohibit GP practices from sitting on ICB boards. We would welcome clarification that the provision for a primary care partner member on the ICB board takes precedence over this amendment.
- There is sufficient flexibility that the amendment allows for community interest companies and the voluntary, community and social enterprise sector to sit on the ICB board. This local discretion is particularly important for ICSs whose community health services are provided by social enterprises.

We also understand that national support and guidance will be available for ICB chairs to advise on specific arrangements and clarify whether, in practice, an ICB member could also be a director / shareholder / employee of any private company. For example, many non-executive directors hold more than one position across different sectors.

Amendments 26, 27 & 28 (Schedule 2)

NHS Providers' view

These three amendments helpfully clarify that the ICB board members set out in the Bill are minimum requirements. However, there is already sufficient clarity in the legislation and accompanying guidance that sets out what the minimum requirements are while enabling sufficient flexibility for ICSs to appoint additional ICB board members locally if they wish to. For example, some larger systems may choose to have multiple trust partner members, whereas some of the smaller systems or those with mature collaborative relationships may choose to have one trust partner member on the ICB board.

Nevertheless, it could be helpful to add 'at least' for the avoidance of doubt, as set out in amendment 26. This would also go some way to reassuring some trusts (particularly mental health, community and ambulance trusts) that there could be more than one trust on the ICB board.

There is a task for ICS leaders to ensure the ICB board remains at an appropriate size for effective decision-making and good governance, and does not become too unwieldy. There should be maximum flexibility for system partners to decide who sits on the ICB, integrated care partnership (ICP) and place-based partnership. Prescribing this level of detail from the centre undermines the principle of subsidiarity underpinning the development of ICSs. The change we would recommend here is to reflect the accepted standard for unitary boards having a majority of non-executive directors to ensure that there is independent oversight of the executive. A non-executive director majority is also necessary to ensure that decisions are subject to appropriate challenge and that there is sufficient assurance that risk is being managed successfully.

Amendment 76 (Schedule 2)

There is a balance to strike between the need for an effective, streamlined board based on the principles of corporate governance and the need for constituent organisations to feel their voices are heard in ICB decision-making. We agree that all provider types – including mental health, community, ambulance and acute trusts – must be involved in ICB decision-making. However, we also accept that there will be too many providers in most systems for them all to be a member of the ICB unitary board. A unitary board requires its members to act in the best interests of the ICS, not their 'home' organisation or sector and then to be severally and jointly liable for those decisions. There should however be a robust mechanism in each ICS to ensure that all constituent organisations are involved in ICB decision-making, as set out for providers in the model constitution for ICBs recently published by NHS England.

Clauses 15-19 (Integrated care boards: functions)

Amendment 92 (Clause 19)

Member's explanatory statement

This amendment will require Integrated Care Boards to prioritise both the physical and mental health and well-being of the people of England and to work towards the prevention, diagnosis or treatment of both physical and mental illness replicating the parity of esteem duty as introduced in the Health and Social Care Act 2012.

NHS Providers' view

We welcome the recognition of the important role that ICBs will have in advancing parity of esteem between mental and physical health.

Following more than a decade of campaigning to dismantle the stigma of mental ill health and achieve equity between the treatment of mental and physical health, progress has been made in a number of areas. Mental health services are reaching more people because of the focus, investment and effort nationally and locally over recent years to improve access to services and deliver on parity of esteem. Since the commitment to parity of esteem, a growing proportion of mental health trusts have received an increase in funding in cash terms.[1]

However, despite welcome investment and focus in recent years and the best efforts of those working in and leading the sector, the healthcare system is still operating in the context of a 'care deficit' where not all those that need help and treatment will seek or be able to access support. There are now 1.6 million people waiting to access mental health services and prevalence data suggests there are many millions more who would benefit from services if they were able to meet the thresholds to access them. There are also continuing instances of mental health services not being prioritised. One such example is the under-prioritisation of investment in the mental health estate, which is having a real impact on trusts' ability to ensure a safe and therapeutic environment. The Prime Minister's announcement on investment in new hospitals almost entirely overlooked the needs of mental health trusts.

[1] See for example analysis by The King's Fund (https://www.kingsfund.org.uk/publications/funding-staffing-mental-health-providers) and NHS Providers (https://nhsproviders.org/mental-health-funding-and-investment/the-mental-health-sector-challenge)

The need to replicate the parity of esteem duty is even more important now given increasing levels of, and often more complex, demand for mental health services, at a time when there is growing unmet need across multiple fronts in health and care and systems face difficult choices around the allocation of resources. The full mental health impact of the pandemic is still emerging, but mental health trust leaders are reporting extraordinary pressures. In particular, a high proportion of children and young people not previously known to services are coming forward for treatment, and they are more unwell, with more complex problems, than the patients previously generally seen by these services.

Sufficient prioritisation and investment in line with the growth in numbers and complexity of mental health demand are crucial to addressing the underlying issues driving the pressures on mental health services and compounding the rising severity and complexity of people's needs. Longstanding system and financial pressures on providers, combined with inconsistent investment in mental health services at local levels, continue to exacerbate bed capacity pressures and increase the likelihood that a person may reach crisis point and require secondary care services. Adequate investment to maintain and build on the steps being taken to grow the mental health workforce, and the sector receiving its fair share of capital funding, are both also crucial. There must also be increased support for public health and social care given the crucial role these services play in providing people with the wider care and support they need for their mental health and wellbeing.

Amendment 51 (Clause 19)

Member's explanatory statement

This amendment requires ICBs and partner NHS Trusts and NHS Foundation Trusts to consult on all revisions to their forward plans.

NHS Providers' view

Trust leaders and system partners recognise the importance of working with local communities to design services and pathways that work for individuals. NHSE/I published guidance in September setting out how ICBs should work with people and communities. Key actions included developing a system-wide engagement strategy by April 2022, setting out arrangements for engagement in ICB constitutions, and ensuring that ICPs and place-based partnerships have representation from people and communities in key forums. Trust leaders and system partners welcome the flexibility afforded by the Bill and accompanying guidance to design what engagement works best for their local populations, and so we do not support any further prescription in the Bill as the requirements are already clear in guidance.

Clauses 21-25 (Integrated care systems: financial controls)

Amendment 69 (Clause 23)

Member's explanatory statement

This amendment would introduce safeguards to limit the possibility of an integrated care board, trust or foundation trust being set a capital resource limit or revenue resource limit that risks compromising patient safety.

NHS Providers' view

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 symbolise a cumulative loss of independent oversight, including:

1. 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;
2. the formal merger of NHSE/I, meaning there will be no process of negotiation between two 'parties' embedded in the development of the NHS payment scheme (unlike the development of the tariff); and
3. the removal of an independent review mechanism to deal with objections to the NHS payment scheme, currently delivered by the Competition Markets Authority (CMA) as part of the statutory objection process for the tariff.

Clause 23 of the Bill (Financial responsibilities of integrated care boards and their partners) proposes that each ICB, and its 'partner NHS trusts and NHS foundation trusts', will be collectively required to deliver financial balance and seek to achieve financial objectives set by NHS England. A separate power will allow NHS England to set additional and mandatory financial objectives specifically for trusts. This builds on the existing duties placed on clinical commissioning groups (CCGs) and trusts under the Health and Social Care Act 2012 and NHS Act 2006 respectively.

We support the intention of these proposals, which is to facilitate greater integration in healthcare and, in doing so, help each ICS deliver on its core purpose to improve outcomes, tackle inequalities, enhance productivity, and drive broader social and economic development. We expect the new financial regime to run smoothly in the vast majority of cases. However, in the extreme event that an ICB, trust or foundation trust feels it has been given an impossible task – for example, if its funding

envelope is insufficient to meet patients' needs, potentially putting outcomes, quality of care and patient safety at risk – it is important that clear routes to recourse and challenge exist. Given the challenging funding situation expected in 2022/23 and 2024/25, we believe that putting these clear routes of recourse and challenge in the Bill will be vital.

As currently drafted, there is no objection mechanism in clause 23 (Financial duties of integrated care boards: use of resources), despite there being a clear link between the funding available to a provider and its ability to deliver safe care. We therefore support the addition of a route of recourse when an ICB, trust or foundation trust considers that its capital resource limit or revenue resource limit risks compromising the safety of patients and believe that an objection mechanism should be added to Bill.

We acknowledge that during the bill committee proceedings the minister addressed what action could be taken if unexpected funding needs arise, explaining that the Department of Health and Social Care can issue funding to NHS trusts and foundation trusts to enable them to continue operating safely. Although we welcome the minister's reference to ensuring emergency funding would be available in certain circumstances, preventing the need for such funding in the first place would be favourable and important to both maintaining quality of care and securing the best value from the NHS' allocations.

The minister also suggested that providers will have a say in how resources will be allocated within their system. However, it is unclear what would happen in the scenario where the ICB is concerned that the system as a whole does not have sufficient funds to ensure patient safety (meaning no amount of negotiation between its constituent organisations would resolve the issue at hand). It therefore remains important that appropriate safeguards exist to mitigate against the risk of an integrated care board, trust or foundation trust being set a capital resource limit or revenue resource limit that risks compromising patient safety.

Amendment 114 (Clause 25)

Members explanatory note

The secretary of state has the function of setting priorities for the Care Quality Commission in carrying out assessments in relation to integrated care systems. This amendment requires the secretary of state to set priorities relating to certain matters.

NHS Providers' view

The secretary of state's powers to set priorities and objectives for the CQC's assessments of ICBs could risk creating a regulatory system that is overly focused on national priorities rather than local population needs, and that could be subject to political influence, impacting CQC's ability to provide independent assurance. The proposed addition of specific domains for the secretary of state to set priorities risks further limiting CQC's ability to respond to the changing landscape across health and social care and design a framework which meets the needs of the system. The existing arrangements, which require CQC to consult the secretary of state, have been successful in providing the necessary assurance so we do not believe there is a need to change what already works or to add prescription in law.

Clauses 34 – 39 (Secretary of State Functions)

Amendment 10 (Clause 34)

Member's explanatory statement

This amendment would require the Government to publish independently verified assessments every two years of current and future workforce numbers required to deliver care to the population in England, based on the economic projections made by the Office for Budget Responsibility, projected demographic changes, the prevalence of different health conditions and the likely impact of technology.

NHS Providers' view

While we welcome clause 34 (Report on assessing and meeting workforce needs) which will place a new duty 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. We support the position set out by a broad coalition of organisations which calls for the secretary of state to publish, every two years, independently verified assessments of current and future workforce numbers consistent with the Office for Budget Responsibility (OBR) long-term fiscal projections.

Ensuring we have the right levels of staff to care for patients now and in future is key – recent analysis from the Health Foundation shows that over a million more health and care staff will be needed in the next decade to meet growing demand for care. The gap between service demand and workforce supply is a significant concern which must be addressed if the NHS is to protect its staff from burnout alongside meeting rising demand pressures and recovering from the COVID-19 pandemic. Our 2021 State of the provider sector report found that almost all (94%) trust leaders were extremely or

moderately concerned about the current level of burnout in their workforce. Pressing workforce shortages and the resulting unsustainable workload on existing staff can only be tackled with a robust long term workforce plan.

Amendment 70 (Clause 39)

NHS Providers' view

As currently drafted, clause 39 gives wide ranging powers to the secretary of state to direct local service reconfigurations and does so without appropriate safeguards.

Decisions on local service reconfigurations are best taken locally by the organisations that are accountable for those services following meaningful engagement with local communities. While clarity and speed can be welcome in making such decisions, this should not be at the expense of local engagement and decision-making. The proposed powers risk undermining local accountability in the NHS, and local authority overview and scrutiny committees. The powers do not necessarily protect the best interests of patients and run the risk of political interference in the provision of local NHS services. In order to ensure that these powers do not adversely affect services and patient care, we believe that the following principles should be set out on the face the Bill:

1. 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. There is an appropriate role for an independent body like the Independent Reconfiguration Panel to provide independent advice on detailed issues including the validity and importance of the clinical case for change;
3. There should be an appropriate threshold governing the level of reconfiguration where the secretary of state is involved; and
4. There should be an explicit test that use of the power must maintain or improve safety before it can be exercised.

Clauses 75-80 (Miscellaneous)

Amendment 60 (Clause 80)

Member's explanatory statement

This amendment is to ensure that social care assessments take place prior to discharge from hospital.

NHS Providers' view

There has been a welcome shift in recent years, and under the NHS long term plan (LTP), towards a 'home first' approach in healthcare, with evidence of better outcomes for patients and improved efficacy across the health and care system. This is reflected in clause 80, which seeks to align the administrative requirements between acute hospitals and community and social care providers behind the discharge to assess approach for the longer term, with widespread support from across the sector. Providers are also clear that there is a strong case for embedding the discharge to assess model to benefit patients and their carers, and they would welcome permanent, dedicated government funding to support the approach.

It is important that the provisions around discharge to assess in the Bill are therefore not seen as a 'COVID-specific' policy – although 'discharge to assess' was funded by government during the height of the pandemic, it accelerated an approach which clinicians and stakeholders across health and care broadly view as an important step forwards for patients and for local health and care systems. This approach does however need to be accompanied by sufficient investment in assessment capacity, domiciliary care and other support, and NHS community services.

To date, the model has contributed to measurable benefits for patients including average reduction in average length of stay – National Audit Office data shows that 30,000 beds were freed up in preparation for the COVID-19 pandemic. Ensuring access to bed capacity remains critical if the NHS is to recover the care backlog in elective surgery and across a range of services. NHSE/I data also shows a 28% reduction in patients staying over 21 days in hospital between winter 202/21 and 2021/22 (when the model was fully funded and implemented).

This is better for individuals as unnecessarily long stays in acute settings can have a negative impact on outcomes for individuals by increasing the risks of an individual becoming ill with a hospital-acquired infection (including COVID-19), losing independence or suffering from mental health issues or muscular deconditioning. The model can also support the appropriate prescription of care and support at home (assessments in a hospital setting can sometimes contribute to over-prescription of care). The approach also benefits public finances – for example, Age UK analysis suggests that every excess bed day costs £346 a day – and the wider health and social care system by improving patient flow from acute to community settings and freeing up capacity to focus on medical need.

The 'discharge to assess' approach follows strategic direction of travel in health and care system by facilitating joined up working across acute, community and social care teams. We cannot therefore support this amendment.

Part 4: Clauses 95-121 (The Health Services Safety Investigations Body)

Amendment 40 & 41 (Clause 108)

Member's explanatory statement

Amendment 40 would define more closely the materials covered by the "safe space" protection provided for by the Bill. Amendment 41 is consequential on Amendment 40.

NHS Providers' view

For HSSIB to be able to properly investigate the systemic causes of safety issues, and to harness the knowledge and insight of those involved, a legally protected safe space is essential. We therefore strongly support amendment 40, which defines more closely materials covered by the "safe space" protection. We believe that by defining in more detail what a "protected material" is and through a robust application of safe space, HSSIB will be able to command the confidence of participants to carry out investigations thoroughly, leading to better outcomes for patients and the health system as a whole.

Amendment 42 (Schedule 14)

Member's explanatory statement

This amendment would remove the provision allowing coroners to require the disclosure of protected material.

NHS Providers' view

We strongly support this amendment which removes a provision in the Bill allowing coroners to require the disclosure of protected material. It is not the duty or purpose of HSSIB to act as a branch of the coroner. The coroner has multiple other avenues of information and powers of investigation, and it does not need access to the HSSIB's protected material simply thanks to the convenience of HSSIB's existence.

In 2019, the Joint Select Committee which reviewed the draft Health Service Safety Investigations Bill concluded: "We recommend that the draft 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".

Amendment 43 (Clause 109)

Member's explanatory statement

This amendment would remove the ability of the secretary of state to make regulations authorising disclosure of protected material beyond that provided for in the Bill.

NHS Providers' view

We believe that the boundaries of safe space should be clear, consistent and constant. We do not support measures which would allow the secretary of state to make regulations authorising disclosure of protected material beyond that provided for in the Bill. Any ability for the secretary of state to change the boundaries of safe space would significantly undermine the trust of participants in HSSIB's investigations. If those taking part in HSSIB investigation do not have trust in the safe space provided, there is a high risk that they will feel unable to share information fully and fearlessly, therefore undermining investigations carried out by HSSIB, and how HSSIB is intended to stand apart from other bodies in the health system. We support this amendment, which would protect safe space boundaries and ensure HSSIB is able to carry out investigations without added barriers or the threat of rule changes in the future.

Amendment 74 (Clause 115)

This amendment would remove clause 115, relating to the ability of the secretary of state to direct HSSIB if he or she considers HSSIB is significantly failing in the exercise of its functions. Clause 115 also gives the secretary of state the ability, should HSSIB fail to comply with his or her directions, to exercise the functions specified or arrange for an alternative person to carry them out.

NHS Providers' view

We recognise and promote the importance of organisational accountability. We would concurrently argue that the independence of HSSIB to act without fear or favour is paramount to its ability to carry out investigations and make meaningful recommendations. Clause 115 as it stands undermines HSSIB's independence more than it establishes accountability. It gives the secretary of state considerable latitude in determining the terms and nature of HSSIB's failure. Given that HSSIB's work and recommendations may well at times to be challenging for the government, it is important to establish lines and modes of accountability which do not create a potential conflict of interest and compromise its independence. We would suggest, for example, that any organisational failure by HSSIB is determined by testing it against the terms of its establishment, rather than through the sole consideration of the secretary of state.

Moreover, and taking a broader strategic lens, we would note that, HSSIB's success or failure arguably depends in large part on whether it is supported and championed across the government and national bodies. It is a body intended to stand apart from the rest of the system so that it can arrive at a clear-eyed analysis centred on patient safety. It will recommend changes which challenge how the NHS works. To take those forward, there needs to be a constant and concerted support for the founding principles of HSSIB and the importance of its work.