The Health and Care Bill 2021

House of Lords, Second Reading, 7 December

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. NHS Providers has commented extensively on the Bill since its publication. Our briefings and written evidence to date 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.
- The Bill gives a new power to NHS England to restrict the spending of any individual NHS foundation trust. We wish to see important safeguards added to this proposal within the Bill to mirror what was agreed in NHS England's 2019 legislative proposals.
- 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 the HSSIB.
- We believe that the new provisions that will give the Care Quality Commission (CQC) scope to assess and rate systems need to be amended so that they 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).

Integrated Care Systems

One of the key elements of the Bill is the focus on developing system working, with integrated care systems (ICSs) to be placed on a statutory footing. We support the government's ambition to embed the success of collaboration and are keen to see an enabling, flexible legislative framework that accelerates the current direction of system working.

However, we would highlight the following considerations which warrant further attention:

- The accountabilities of Integrated Care Boards (ICBs) can be defined 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. We want the Bill to be amended to incorporate all three as this will ground ICBs in their communities and keep their focus on serving patients and service users.

- The accountability of ICB chairs locally is important and speaks to the purpose of the closer integration of health and care and the ability of local systems to best serve the needs of their communities. While we welcome the minister's reassurance that there will be guidance on how NHS England could remove the chair and what the thresholds will be, we continue to be concerned that ICB chairs only seem to be answerable to the secretary of state. In line with

good governance practice, we want to see equal provision in the Bill for the Integrated Care Board membership to remove their chair if they fail to secure the confidence of the board.

- It is essential to ensure the views of the full range of provider types are heard as part of the ICB decision-making process. This parity in decision-making is critical if we are to implement the collaborative approach to planning and delivering more integrated care, as intended. However, there is a tension here between a fully inclusive approach and the need for a streamlined board which allows for effective decision-making. We are therefore not arguing for specific legal provisions for each segment of the provider sector to be represented on the board of the ICB, but we do want to see a robust mechanism added to the Bill so that providers can feed into and influence ICB decision-making.

We believe that governance will be further enhanced by adding the following to the Bill

a. A requirement to consult all trusts and foundation trusts within the ICB area (as well as primary care and local authorities) in developing the ICB composition and constitution, and in any proposed change to ICB boundaries;
b. Provision for a challenge mechanism for trusts and foundation trusts to raise concerns to NHS England about the ICB composition, constitution and plans if necessary/in extremis;
c. 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.

Private sector representation on ICB boards

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 to a certain extent).

The Bill 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 ICS implementation guidance. The ICB chair effectively has a veto on all appointments.

The Bill prevents the appointment of a member to an ICB 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 trust leaders are clear that private providers are an important partner in local health and care systems, not least in contributing to the pandemic response and recovery by providing additional capacity for elective procedures in particular. They are also a key delivery partner in many mental health provider collaboratives. Trust leaders are also keen to ensure this provision does not unintentionally limit local flexibilities to engage with primary care colleagues and the voluntary sector. We set out a number of considerations below:

- 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 tend to be significantly smaller than those awarded to NHS providers and focus on particular services. There remains a significant proportion of healthcare which only NHS organisations hold the infrastructure, and expertise to provide (with significant barriers to entry for alternative providers). In fact, there has been no significant increase in the share of the NHS' total revenue budget going to private providers, which has stayed relatively stable at around 7%.

- The proposed governance model for ICBs means they will have a unitary board comprising individuals who are not present as a representative of their sector but to take collective responsibility for decisions to best serve the local population, deliver and improve care. Effectively managing potential conflicts of interests when awarding contracts, will be essential for ICBs regardless of whether private sector partners are included on the board.

- The Bill will place the onus on ICB chairs to consider, during the appointment process for ICB board members, whether a candidate's involvement with the private sector could be seen as undermining the independence of the NHS. While we welcome assurances given by the minister during Report Stage in the House of Commons that this will not prohibit GPs from sitting on ICB boards as the primary care partner member, we would welcome further clarification from the government that the provision in the Bill requiring a primary care partner member on the ICB board takes precedence over this. Furthermore, we would welcome assurances these provisions will not prevent community interest companies and the voluntary, community and social enterprise sector from sitting on the ICB board. This local discretion is particularly important for ICSs in which some or all community health services are provided by social enterprises or voluntary sector organisations.

Care Quality Commission reviews of integrated care systems

We are broadly supportive of these provisions as they provide the mechanism for ICSs to be held accountable for the decisions they make that affect the quality and safety of care within their geographical footprint. Recognising that NHS trusts do not operate in a vacuum, it is important to understand the link between leadership and decision making at system level and the quality of care being delivered at an organisational level.

These provisions, including accountability of the CQC to the secretary of state, broadly mirror existing arrangements, but there are provisions which could impact on the CQC's ability to provide independent assurance. In particular, 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. We support the recommendation made by the CQC, calling for a government amendment such that only substantial changes to quality indicators, frequency, and methodology for CQC reviews require secretary of state approval. This will allow the CQC to make minor changes dynamically in response to rapidly evolving issues, without being impeded by cumbersome bureaucratic processes each time.

During proceedings in the Commons committee, the minister provided some welcome clarity on the expected audience for a CQC system-level assessment, stating that the CQC will have to ensure that the public will have access to the information about the provision of care in their area. The minister also stated that he expects that system partners will want to develop actions in response to these reports. We would welcome clarity from the government on how an assessment at system level would add value for a patient or service user, given it is registered service providers that deliver the care to them directly.

There is also a risk that measuring outcomes, quality or safety at ICS levels will duplicate (or simply aggregate) provider level assessments. While we agree with the minister's statements in the Commons committee, that the experience and outcomes of people who use health and care services should be central to these reviews, assessing experiences will be challenging at this level given the geographical scale and interactions across a system. A focus on an ICSs' engagement with different communities within a wide-ranging footprint may be a more effective approach. There may also be challenges regarding assessing the strength of relationships across an ICS and determining how this directly impacts on the quality of care across a whole system.

The provision is helpfully permissive with regard to how the CQC is to conduct its reviews and assessments, which we hope will enable the CQC to evolve its approach as ICSs become more established. It is clear that the CQC will need to consult with NHS England before it prepares or revises the statement which sets out the frequency with which reviews are to be conducted and the period to which they are to relate. Alignment with NHS England, in particular its system oversight framework, is vital to reducing any risk of duplication in assessments. We also believe ICBs, NHS trusts and foundation trusts, and system partners must also be consulted on any revisions to the CQC's statement and would feel more comfortable if this were specified in the bill.

Financial responsibilities of integrated care boards and their partners

Clause 24 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 will be vital and would urge the government to look at this issue in more detail.

As currently drafted, there is no objection mechanism in clause 24, 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.

During proceedings in the House of Commons, the minister addressed what action could be taken if unexpected funding needs arise, explaining that DHSC can issue funding to NHS trusts and foundation trusts to enable them to continue operating safely. Although we welcome this 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 securing the best value from the NHS' allocations.

Report on assessing and meeting workforce needs

While we welcome clause 35 (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 proposes an amendment to the Bill 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.

Powers of Direction

Clause 39 of the Bill (General power to direct NHS England), as currently drafted, appears to open up the possibility of ministers' involvement in aspects of the operational management of the health service. We are concerned that without appropriate safeguards in place, decisions might be reached based on political motivation rather than focused on the best interests of services and populations.

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 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:

a. 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.

b. 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.

c. 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.

A lack of safeguards could arguably expose the government, any secretary of state, the service, and patient care to undue, unmanaged risk. We believe there needs to be further discussion about whether such broad powers are necessary and proportionate. We believe that any direction given by the secretary of state should be in the public good, its impact should be understood, and such impacts should be reviewed so that adverse effects can be rectified.

We recognise the logic of the secretary of state having powers to move responsibilities between arm's-length bodies via secondary legislation as set out in Part 3 of the Bill. 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.

Reconfiguration

Clause 40 (Reconfiguration of services: intervention powers) gives the secretary of state intervention powers in relation to the reconfiguration of NHS services. As currently drafted, this 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. They 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 this power does not adversely affect services and patient care, we believe that the following principles should be applied and set out on the face the Bill:

a. 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;

b. 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;

c. There should be a serious and substantial threshold governing the level of reconfiguration where the secretary of state is involved; and

d. There should be an explicit test that use of the power must maintain or improve safety before it can be exercised.

Capital spending limits for NHS foundation trusts

The Bill puts forward clause 54 (Capital spending limits for NHS foundation trusts) 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 DHSC and NHS England to ensure that the national capital expenditure limit cannot be breached.

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 £9.2bn. Half of this is considered a 'high' or 'significant' risk to patients and staff. We are 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 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 on 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.

The current drafting does not mirror 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". NHS England's 2019 legislative proposals contained a series of detailed safeguards that we consider essential to see in the Bill. These are:

a. The power to set capital spending limits for foundation trusts is circumscribed on the face of the Bill as a narrow reserve power;
b. Each use of the power should apply to a single named foundation trusts individually;
c. Each foundation trust's capital spending limit should automatically cease at the end of the current financial year;
d. 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
e. 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. We want to see the government honour the agreement reached in 2019 and add the agreed safeguards to the Bill.

Health Services Safety Investigations Body (HSSIB)

We strongly support the principle of creating the HSSIB as an independent statutory entity and enabling it to conduct safe space investigations so that the NHS can improve patient care and learn when things go wrong. Organisational cultures that support staff to speak up have higher levels of staff engagement and patient satisfaction and are associated with reduced errors in care and better safety. In 2019, the Health Service Safety Investigations Bill was published but did not progress through parliament. We are pleased to see a number of helpful revisions to those earlier provisions, but we want to ensure that these 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. 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 in the Bill.

We are also concerned that the exceptions on prohibition of disclosure of protected materials are wide ranging and unreasonably open to external applications for access. 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.

We are further concerned about the provision in the Bill (Clause 38 Power of direction: investigation functions) which would allow the secretary of state to direct the HSSIB. It is critical to the effectiveness of the HSSIB that it is independent and able to investigate the health system, and make recommendations in support of improving patient safety, without fear or favour. This is what makes the HSSIB distinct from other national bodies, and it must be preserved for the sake of its credibility and integrity.

Social care cap

Clause 140 of the Bill amends the Care Act 2014 to change the way that people who are eligible for means-tested support meet the cap. Local authority financial contributions will no longer count towards an individual's contribution to care costs. Instead only personal financial contributions will count towards the cap meaning those eligible for means tested support from the local authority will contribute the same costs towards their care (if they reach the cap) as wealthier individuals, but over a longer period of time than if they did not benefit from local authority support. This effectively reduces the benefit for those who are less financially well off.

While the introduction of the cap on lifetime care costs is a welcome start to reforming the social care system, and the new cap will protect more people from catastrophic care costs than in the current system, we are concerned that the government's proposed amendment to the Care Act 2014 is a regressive step that will leave far fewer people protected from catastrophic care costs than the government originally proposed in September. It will also disproportionately impact those with lower levels of wealth, creating a less equitable system. We were particularly disappointed by the fact the government did not publish an impact assessment, which makes it difficult to ascertain how many people will be adversely affected. We expect the full impact assessment to be published in the new year.

This change in how the cap will be implemented also risks exacerbating regional disparities at apparent odds with the government's 'levelling up' agenda because it will impact people in regions of the country with lower house prices (generally midlands and in the north) harder than it does those in regions with higher house prices (generally those in London and the southeast). Those areas of the country with lower average house prices often also have higher levels of deprivation and people are

more likely to experience long-term health problems and need social care support, thus again exacerbating rather than alleviating, structural inequalities.

Clause 140 – and the government's proposals for social care reform as a whole – fail to address the significant issues facing the social care sector. The cap may help to limit some people's costs, but it does not in itself inject more money into the system, improve care, increase access or address workforce issues.

The cap also seems to overlook the importance of supporting working age adults with care needs, who will be required to contribute towards the £86,000 cap at the same rate as older people. They will therefore face catastrophic care costs over their lifetime due to typically long care pathways, thus creating an unfair system for a significant group of people (half of all social care spending goes on working age adults). The original recommendations by the Dilnot commission aimed to combat this inequity by suggesting that those who enter working age with an existing social care need should not have to pay for their care.

The cap must therefore sit alongside other reforms aimed at supporting a social care system that is facing ever increasing demand and more complex needs. We need a sustainably funded social care system that supports adults of all ages to remain well and independent in the community, not only to ensure they live fulfilling lives but also to protect the NHS from avoidable pressure.