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Health Foundation briefing for the House of Commons Public Bill Committee on the Health and Care Bill 2021-22

About the Health Foundation

The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK. Our aim is a healthier population, supported by high quality health care that can be equitably accessed. We learn what works to make people's lives healthier and improve the health care system. From giving grants to those working at the front line to carrying out research and policy analysis, we shine a light on how to make successful change happen.

Introduction

The Health and Care Bill 2021-22 outlines major changes to NHS rules and structures in England. The bill is the largest legislative shake-up of the NHS in a decade—and undoes many of the changes introduced by the Coalition government in the last round of major NHS legislation back in 2012.

Broadly speaking, the bill is a story of two halves. The first is a set of changes designed to promote collaboration in the health system. Encouraging collaboration to improve care makes sense—and goes with the grain of recent NHS policy. But the benefits of these changes should not be overstated and there is a risk that the new NHS structure is complex, vague, and not adequately designed to support the bill's aims for better integration between NHS and wider services. The second is a set of changes to increase the power of the Secretary of State for Health and Social Care over the day-to-day running of the NHS. These changes lack rationale and warrant scrutiny. The bill also includes a set of wider changes on workforce policy, social care, public health, and other areas. In this briefing, we focus on the key changes in the bill and highlight issues and questions for the committee to consider. We draw on our previous analysis of the reform proposals and their potential impacts.[1,2,3,4,5]

Integration and collaboration

The bill includes a range of measures to encourage collaboration within the health and care system. These changes were proposed by national NHS bodies[6,7] and try to resolve the longstanding tension between the 'rules in form' and the 'rules in use' in today's NHS.[3] Under the plans, every part of England will be covered by an integrated care system. These currently exist informally in 42 areas, serving populations of around 1 to 3 million. Each system will be made up of two new bodies: 'integrated care boards' (ICBs)—area-based NHS agencies responsible for controlling most NHS resources to improve health and care for their local population—and 'integrated care partnerships' (ICPs)—looser collaborations between NHS, local government, and other agencies, responsible for developing an 'integrated care strategy' to guide local decisions. Clinical commissioning groups will be abolished and their functions taken on by the new ICBs. Requirements to competitively tender some clinical services will be scrapped, though exactly what will replace them is currently unclear.

Overall, the emphasis on collaboration between the NHS, local government, and others makes sense, and builds on recent national policy initiatives in the NHS. But the potential benefits of greater collaboration—both within the NHS and between NHS and wider services—have long been overestimated by policymakers.[8,9] Making collaboration work also depends as much on culture, management, resources, and other factors as it does on rules and structures.[10,11,12] Formal duties to collaborate or mergers of NHS functions do not necessarily produce collaboration in practice.

The new structure risks being complex and vague. For example, the relationship between NHS providers and ICBs is unclear. How much power will the ICB have over its constituent providers? How will ICBs hold new provider collaboratives to account? And how will NHS providers balance their duty

to collaborate with existing responsibilities as individual organisations? ICPs seem to play a bit-part role in the new system—responsible for developing an integrated care strategy (of which many similar local plans already exist)—and risk being side-lined by the more powerful NHS ICBs. This would undermine the bill's aims for better integration of services beyond the NHS and limit the ability of local systems to tackle social and economic factors that shape population health and health inequalities.

Establishing a new regional tier of the NHS in England through ICBs could improve the murky accountabilities in today's health system. NHS policymakers have a long history of reinventing the "intermediate" tier of the health service[13]—and most national public health care systems have some form of regional management layer. But creating organisations is easier on paper than in practice: experience shows that merging and creating new agencies can cause major disruption.[14] There is limited detail on how the performance of newly established ICBs will be assessed and reported. There is also a risk that creating larger geographical units to manage NHS budgets leads to less equitable distribution of funding, depending on how decisions about allocating money within ICBs are made.

It is also unclear how the "place" level of the new NHS—sitting below ICBs—will be organised. National NHS guidance and the white paper describe how some ICB powers and budgets will be delegated to 'places'. This makes sense—and it is understandable that there should be some local flexibility in these arrangements. But the bill is almost silent on how key NHS functions, such as the commissioning of primary care, will operate within ICBs. The support, management, and oversight of primary care requires a strong support structure at a local level. The bill should provide more detail on how this will be done. There is a risk of confusion and lack of continuity over key NHS decisions as ICBs develop. A clear and transparent framework will also be needed to guide ICB commissioning decisions (as requirements to competitively tender clinical services will be scrapped by the bill).

Key questions for the committee include:

- Do Ministers have clear and realistic expectations for what integrated care systems will be able to deliver in terms of improved quality of care, better population health, reduced health inequalities, and better value for money?
- How will Ministers ensure ICPs are able to have an appropriate level of influence and involvement in the decisions made by ICBs? What support will ICPs have for the formulation of integrated care strategies and what role will ICPs have in the implementation and monitoring of those strategies?
- How will integrated care systems be held to account for progress? Will performance assessment of ICBs focus on longstanding NHS priorities (e.g. waiting times) or give equal emphasis to the broader ambitions to integrate care, improve population health and address health inequalities?
- Can Ministers clarify how relationships between NHS providers and provider collaboratives are expected to work in practice? How will ICBs hold the new provider collaboratives to account, and how will providers balance existing duties as individual organisations with new duties to consider the wide effects of decisions?
- Can Ministers provide a clearer account of how the lower 'place' tier of the new English NHS will function? What role will 'place' have in primary care commissioning and how is this function expected to be discharged in practice?
- What is being done to develop a supporting infrastructure for 'place', including access to data, and analytical and commissioning support?

Secretary of state powers

The bill gives wide ranging new powers to the Secretary of State. These include powers to direct NHS England in relation to almost all its functions and intervene at any stage in service reconfigurations (such as decisions about merging or closing hospitals). NHS leaders must notify the health secretary about proposals to reconfigure services. And the health secretary will be able "retake" decisions already made by NHS leaders, as well as direct them to consider new service changes. These proposals are concerning and risk politicizing decisions about how local services are delivered.

How these changes will benefit patients is unclear—and they might make things worse. Decisions about service changes are complex, and evidence to inform them is often limited and disputed.[15,16] Independent judgment has been used in the past to reduce ministerial involvement in contested decisions.[17] Accountability will always rise upwards to politicians in a tax funded health system. But these changes seem to be more about enhancing central control rather than improving accountability. Greater ministerial involvement risks slowing down or blocking local proposals that could improve care for patients—as has happened in the past. It may also undermine the bill's focus on giving power to local leaders to improve population health.

The National Health Service Act 2006, as amended by the Health and Social Care Act 2012 from 1 April 2013, gave the Secretary of State a range of oversight, accountability and intervention powers over NHS England.[18] Through the mandate, the Secretary of State may set objectives NHS England must seek to achieve and requirements it must comply with (section 13A). The Secretary of State is also able to issue legal directions to NHS England in the event of a serious failure to discharge its functions (section 13Z2) and in the event of an emergency (section 253). The power to set legally binding requirements via the mandate does not appear to have been exercised – save to give effect to the Better Care Fund via a specific amendment included in the Care Act 2014.[19] It is unclear when, if ever, the failure and emergency powers have ever been exercised. The previous Secretary of State, Jeremy Hunt, has said that he never felt he 'lacked a power to give direction' when he needed to under existing legislation.[17]

If government intends to retain these parts of the bill, greater detail is needed on the scope of the new powers, how and when they can be used, and what oversight will be in place to ensure decisions are made fairly, transparently, and without undermining the wider aims of ICS policy. For example, the circumstances in which the Secretary of State can direct NHS England should be clearly defined, along with the process for parliamentary scrutiny of these decisions and requirements for reporting on them. New powers in the bill for the Secretary of State to intervene in service reconfigurations are particularly concerning. Ensuring that decisions on local service changes are informed by independent advice and transparent criteria will be essential. The bill's explanatory notes suggest that the current Independent Review Panel will be maintained and guidance will clarify how the Secretary of State may use independence advice to guide decisions on reconfigurations. But much clearer limits and safeguards are needed on ministerial intervention.

Key questions for the committee include:

- What is the rationale for the sweeping new powers of direction and intervention in the bill? How are the new powers intended to be used?
- Can Ministers provide specific examples of difficulties caused by the absence of such powers and how the new powers would support better patient care and improved population health?
- Why do Ministers consider the existing powers of oversight, accountability and intervention insufficient? Can Ministers account for how and when those powers have been exercised since being brought into effect from 1 April 2013?
- How will Ministers be held to account to ensure the new powers are exercised in an appropriate and transparent manner, with decisions made after relevant consultation and based on expert advice?
- What assessment have Ministers made of the risk that the new powers may undermine the wider policy objectives of the legislation?
- What consultation has been undertaken with ICS leaders and partners from the NHS, local government and the VCSE to understand the potential impact of these powers on local relationships?

Health inequalities

The provisions of the bill that are designed to encourage action on health inequalities largely amount to more of the same, transposing current CCG duties onto ICBs (see table below).

Covid-19 has exposed and exacerbated existing health inequalities in England.[20] As explored in our forthcoming paper assessing delivery against the NHS Long Term Plan, progress on national NHS commitments related to reducing health inequalities has been slow in recent years. NHS England has urged local systems to accelerate action to tackle inequalities after the pandemic.[21] To help do this, there is scope for the bill to be strengthened to support more tangible NHS action to narrow health inequalities.

The core aspect of the bill designed to drive NHS action on health inequalities is a duty placed on ICBs to ensure that they 'have regard to the need to reduce inequalities between patients' with respect to both access to and outcomes from provision of health services. This requirement is mirrored in a separate 'duty to promote integration' that the bill places on ICBs. Various reporting requirements are also placed on ICBs to plan and report on how they discharge these inequality duties, and a similar duty applies to the Secretary of State. All are carried over from the duties and requirements that applied to CCGs and do not mark a change from the existing legal framework.

The framing of this core inequalities duty as it currently stands is narrowly focused on access to and outcomes from health services. The bill misses an opportunity to recognize and encourage the wider role that can be played by NHS organizations as 'anchor institutions'. Due to their size, scale, and rootedness in local communities, NHS agencies have the potential to influence social, economic, and environmental factors that shape health and health inequalities in their area. This includes considering how buildings and spaces are used to support communities, widening access to quality work, and adjusting the way in which goods and services are purchased locally.[22] The core inequalities duty could be broadened so that it specifies the need to act in partnership with other agencies on wider social and economic determinants of health, and recognizes the NHS's potential as an 'anchor'.

A second key area where the bill could be strengthened relates to the 'triple aim' – a new duty that would be placed on NHS England (clause 4), ICBs (clause 19), NHS trusts (clause 43) and foundation trusts (clause 57) to ensure they consider the effects of their decisions on the health and wellbeing of the population, quality of care, and the sustainable use of NHS resources.[23] The duty is designed to drive action on a set of common, system-wide goals that require collective action between NHS and wider agencies. To send a clear signal about the importance of narrowing inequalities, the triple aim could be amended so that it explicitly references the need for organizations to consider the impact of their decisions on efforts to reduce inequalities. Clause 4 of the bill currently states that NHS England 'may' publish guidance about the discharge of this duty. This could be strengthened to ensure that details on action to reduce inequalities—for instance, against specific goals and metrics to reduce inequalities—must be published.

	National Health Service Act 2006 (as amended by the Health and Social Care Act 2012	**Health and Care Bill 2021-22 (As introduced)**
Legal duties on inequalities	The Secretary of State must have regard to the need to reduce inequalities between the people of England with respect to the benefits people can obtain from the NHS [section 1C]	No change
	NHS England/CCGs must, in the exercise of its functions, have regard to the need to reduce inequalities between patients with respect to access to, and outcomes from, health services [sections 13G and 14T]	For CCG, read ICB – otherwise no change [new section 14Z35 inserted by clause 19]
Inequalities in other duties	Duty to promote integration: Functions of NHS England/CCGs must be exercised with view to health services, health-related services and social care	For CCG, read ICB – otherwise no change [new section 14Z42 inserted by clause 19]

	services being provided in an integrated way where this would improve quality or reduce inequalities in access or outcomes [sections 13N and 14Z1]	
Annual plans	NHS England's business plan and CCG commissioning plans must explain how the duties to reduce inequalities is to be discharged [sections 13T and 14Z11]	For CCG commissioning plan, read ICB joint forward plan – otherwise no change [new section 14Z50 inserted by clause 19]
Annual reports	NHS England and CCG annual reports must assess how effectively the duty to reduce inequalities was discharged [sections 13U and 14Z15]	For CCG, read ICB – otherwise no change [new section 14Z56 inserted by clause 19]
Performance assessment	NHS England's annual assessment of how well each CCG has performed must include an assessment of how effectively the CCG discharged its duty to reduce inequalities [section 14Z16]	For CCG, read ICB – otherwise no change [new section 14Z57 inserted by clause 19]

Key questions for the committee include:

- Has the current legal framework for CCGs enabled the NHS to make sufficient progress in reducing inequalities between patients with respect to access to and outcomes from health services?
- How might the proposed provisions for ICBs be strengthened to support the necessary step change in action on health inequalities, as highlighted during the COVID-19 pandemic?
- Should the scope of the duty for ICBs to 'have regard to the need to reduce inequalities between patients' be broadened to capture the need to act on wider social and economic determinants of health and better recognize the NHS's potential as an 'anchor' institution?
- With levelling up and addressing health inequalities being a central objective for the NHS and government, how should the government ensure that inequalities is incorporated into the 'triple aim' and prioritized in local activity?
- Should there be an explicit requirement for the statutory guidance on the triple aim duty and the performance assessment of ICBs to ensure more specific goals and metrics are included on health inequalities?

Workforce

Staffing shortages are the biggest challenge facing the NHS and social care. Before covid-19, staffing gaps stood at around 100,000[24] in the NHS and 122,000 in social care.[25] During the pandemic, staff have worked under incredible strain and put themselves at risk to help others. Staff are exhausted; some feel abandoned.[26] Social care workers have been more likely to die from covid-19 than others of the same sex and age.[27] The long-term impact of covid-19 on the health and care workforce is not yet clear, but estimates suggest the NHS could face staffing gaps exceeding 475,000 by 2033/34[28] and social care is projected to require 480,000 more jobs by 2035 on current population growth trends.[29]

Measures in the health and care bill to improve workforce planning are limited and weak. The bill places a duty on the Secretary of State to publish a report at least every five years describing the system for assessing and meeting future workforce needs. But this is an inadequate response to the challenges facing the system. The bill should be used to strengthen workforce planning processes to avoid a vicious cycle of growing staff shortages and declining quality. With other organizations, we have proposed that a clause be added to the bill to ensure that independently verified projections of workforce supply and needs in health and social care (needs consistent with the Office for Budget Responsibility long-term fiscal projections) are produced and published regularly, at both the national and regional levels, at least once every two years[30]

This clause may help support better decision-making over the long-term. But better projections alone will not be enough to tackle the chronic workforce issues in health and care. Both sectors need long-term workforce strategies, supported by multiyear government investment. They currently have neither. Changes to the health and care bill to strengthen workforce planning must therefore be supported by wider government action to expand the workforce and improve conditions for staff.

Key questions for the committee include:

- Will Ministers accept the proposal for the bill to include an explicit requirement for the Secretary of State to publish independently verified projections of workforce supply and needs at least once every two years?
- How might long-term workforce strategies for the NHS and social care be prioritised in the aftermath of the pandemic?
- How can the regional level in workforce planning in health and in social care be fully developed and aligned?
- To what extent could multi-year workforce strategies be further integrated with the government's long-term plans for investment in the NHS and social care?

Data sharing

Data has played a critical role in the response to the pandemic. Sharing data across organisational boundaries has helped to inform national and international policy on covid-19, driven rapid innovation across the NHS and other services, and supported the development of new treatments and vaccines.

The bill outlines steps to clarify and improve data sharing between health and social care bodies. This should support efforts to coordinate services in integrated care systems. But to improve population health, data sharing will need to go beyond health and social care data and include the wide range of other services that are provided by local authorities. While the bill would give ICBs a duty to promote research (replicating the existing duty on CCGs), there is little detail included on the use of data for research purposes.

There are longstanding weaknesses in how social care data are used, collected, and shared.[31,32] A lack of data on social care has affected the pandemic response.[33] The bill's provision for both public and private care providers to share client-level social care data, as well as other information from and about the providers of social care, should help to address some of these structural problems in the sector. But the focus appears to be primarily on outputs (for example, data on capacity and risk) and has less information about improving data on outcomes and patient experience for social care users.

There are many advantages to sharing data to improve health and care, but it is essential that this is done in a clear and open way. The recent debate around the General Practice Data for Planning and Research programme[34] has highlighted the sensitivities that surround any discussion about the collection and sharing of health and care data.

Government must be transparent on how data will be used and should engage with the public and health and social care professionals to build trust. To be successful, policies must also go beyond what data are collected to consider how they are used to improve care – including the investment needed to boost data infrastructure, data literacy, and the effective use of data analytics.

Key questions for the committee include:

- How will the Bill enable the sharing of data beyond health and social care, and will it enable data sharing in relation to the wide range of other services provided by local authorities?
- How will Ministers ensure that the risk posed by the potential increased burden of data collection on providers of adult social care is appropriately mitigated, and what steps will be taken to ensure that data collected is of sufficient quality and completeness?
- What steps will be taken to ensure that data collected about adult social care enables not just better measurement of the care that is being delivered, but also better understanding of unmet

need? And, what steps will be taken to ensure the data collected is measuring what matters to service users in terms of outcomes and experience?
- How will Ministers ensure that there is appropriate engagement with the public, health and social care providers and health and social care professionals in developing plans for the collection or sharing of data? In particular, how will this be implemented in designing the proposed new adult social care data collection?
- How will the Bill support reciprocal sharing of data, or insights derived from that data, with commissioners and providers of health and social care services?
- What steps might be taken to ensure that the social care workforce is equipped with the skills and tools necessary to enable the proposed collection, reporting and sharing of data?

Implementation and wider context for reform

Covid-19 has been the biggest shock in the NHS's history and the impacts of the pandemic on people's health and health services will be felt for many years to come. The health policy challenges facing the NHS and government as the country emerges from the pandemic are enormous, including tackling the growing backlog of unmet health needs, dealing with chronic staffing shortages, reducing vast health inequalities, reforming England's broken social care system, and more. The bill will do little to tackle these fundamental challenges and risks distracting the NHS as it tries to recover services.

Government and the NHS should be realistic about the potential impact and limitations of the bill. Previous NHS reorganizations have delivered little measurable benefits.[35,36,37,38,39] Reorganizations can have negative effects, such as destabilizing relationships and delaying care improvements.[40,1]

In this context, a careful and flexible approach to implementing the changes will be needed to minimise potential disruption—and the timetable for implementation should be kept under review. This is particularly important given the widespread and growing pressures on health and care services, the uncertainty created by covid-19, and the potential disruption to services over winter 2021/12.[41] Local NHS teams will need time and resources to implement the changes set out in the bill. Improving collaboration between agencies will depend on culture, management, resources, and other factors. National NHS bodies must consider the wider policy changes needed to support this way of working.

Wider reform and investment are also needed to improve health after the pandemic. Government currently has no national strategy for reducing health inequalities in England and public health budgets were 24% smaller per capita in 2021/22 than 2015/16.[42] Ongoing failure to reform adult social care and continued underinvestment will leave vulnerable people without the care they need. The need for fundamental reform of adult social care has been clear for decades, yet successive governments duck reform and people continue to suffer. The health and care bill will have limited impact without more systemic policy action to improve health and reduce inequalities across society.

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