

Briefing for Peers: Health and Care Bill, Second Reading

Tuesday 7th December 2021

Opportunities to put the NHS and social care on a fairer and more sustainable footing

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.

The Health Foundation has welcomed the Bill's broad emphasis on **increasing collaboration** between different parts of the health and care system. Although the benefits of these changes should not be overstated, increasing collaboration to improve care makes sense and goes with the grain of recent NHS policy.

But the Bill misses opportunities to support the NHS to recover from the impact of the pandemic and improve productivity across three key areas: **workforce shortages**, **health inequalities** and **data sharing**. There are also some aspects of the Bill that require closer scrutiny – including proposed **increased powers for the Secretary of State** over the day-to-day running of the NHS, and **changes to the social care cap** which could leave poorer homeowners with catastrophic costs.

This briefing provides our analysis of the key proposals within the Bill. It explores the potential implications of the changes, providing recommendations for how the Bill could be improved as it enters the House of Lords and how it can be effectively implemented in the context of wider reform.

Integration and collaboration

Under the plans in the Bill, every part of England will be covered by an 'integrated care system' (ICS). These currently exist informally in 42 areas of the country, 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 the NHS, local government, and other agencies, responsible for developing an 'integrated care plan' to guide local decisions.

Clinical commissioning groups (CCGs), currently responsible for purchasing NHS services, will be abolished and replaced by the new ICBs. Existing 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 through ICSs makes sense, and builds on recent national policy initiatives. But the potential benefits of greater collaboration – both within the NHS and between NHS and wider services – have long been overestimated by policymakers.^{1,2} Making collaboration work also depends as much on culture, management, resources, and other factors as it does on NHS rules and structures.^{3,4,5} Formal duties to collaborate or mergers of NHS functions do not necessarily produce collaboration in practice. National NHS bodies must consider the wider policy changes needed to support this way of working.

The new structure also risks being complex and vague. The relationship between NHS providers and the new ICBs is currently unclear. There is limited detail on how the new ‘place’ level of the NHS will be organized. ICPs also look as if they will play a bit-part role – responsible for developing an integrated care strategy (of which many similar local plans already exist) – and risk being side-lined by more powerful NHS agencies. 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 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 – 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.⁶ 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.

Key questions

- Do Ministers have clear and realistic expectations for what ICSs 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?

Tackling workforce shortages

Workforce shortages are the biggest challenge facing the NHS and social care. Pre-existing staff shortages have been exacerbated by the pressures staff have experienced working through the pandemic. Staff are exhausted; some feel abandoned. If there are not enough staff to deliver extra services, the NHS will be unable to clear its record backlog and improve the quality of care. Failing to address workforce shortages would undermine recent investment in health and care.

The Health and Care Bill provides a major opportunity for Government to create a better system for workforce planning, yet the Bill only includes some limited measures. Clause 34 puts a duty on the Secretary of State to publish a report describing the system in place for addressing and meeting workforce need every five years. But this fails to address whether the system is training, educating and retaining enough people to deliver services now and in the future. Outside of the statutory requirements set by this Bill, Health Education England's Framework 15 review will not solve the ongoing data gap on health and care staffing numbers, which is crucial to inform strategic workforce planning decisions.

We supported the amendment to Clause 34 tabled by Jeremy Hunt MP at Report Stage in the House of Commons, which would have required the Secretary of State to publish independently verified assessments of current and future workforce numbers every two years – consistent with the Office for Budget Responsibility (OBR) long-term fiscal projections. This would strengthen long-term spending decisions about workforce planning, regional shortages and skill mix based on evolving trends.

We were disappointed that the amendment was not accepted by the Government, despite support from over 60 health and care organisations – including the Health and Social Care Select Committee.

Expanding the health, public health and social care workforce so it can keep pace with demand will require significant investment – but not investing in workforce retention and expansion also comes at a cost. In 2019/20, £6.2bn was spent on agency and bank staff in hospitals in England to plug workforce shortages.⁷ Smarter long-term investment in the workforce presents opportunities to limit costs on short-term spending when services come under pressure.

Key questions

- 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?
- 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?

Reducing health inequalities

Covid-19 has exposed and exacerbated existing health inequalities in England, and the government has committed to 'levelling up' the country.⁸ Progress on national NHS commitments related to reducing health inequalities has been slow in recent years,⁹ and NHS England has urged local systems to accelerate action to tackle inequalities after the pandemic.¹⁰ There is scope for the Bill to be strengthened so that it supports more tangible NHS action to narrow health inequalities.

As explored in our recent long read, the Bill's current provisions relating to health inequalities amount to more of the same, transposing existing inequality duties for CCGs onto the new NHS ICBs. As with the existing legal framework for CCGs, it places duties on ICBs and on the Secretary of State to have regard to the need to reduce inequalities between patients with respect to both access to and outcomes from provision of health services. Both are also required to plan and report on how they discharge these inequality duties. However, there is currently no explicit requirement for NHSE to publish national guidance about which performance data and indicators relevant to health inequalities should be collected, analysed and reported on by NHS bodies.

The NHS's current 'system oversight framework' – used to define national priorities and monitor the overall performance of local systems – also includes little in the way of concrete measures on health inequalities, with those that are included focused primarily on shorter term COVID-19-related equity impacts.¹¹ To help drive more action and enable better tracking of progress across different areas, the Bill should be amended to require NHS England to publish guidance on collecting analysing, reporting and publishing data on all factors or indicators relevant to health inequalities. The Health Foundation has drafted an amendment designed to provide for this (see appendix) which was selected for debate at Report Stage in the House of Commons but was not put to a vote.

Another key area where the Bill could be strengthened to encourage action on health inequalities relates to the new 'triple aim' outlined in the Bill. This requires NHS England, ICBs, NHS trusts and foundation trusts 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. To send a clear signal about the importance of narrowing inequalities, we are supporting calls for the triple aim to be amended so that it explicitly references the need for organizations to consider the impact of their decisions on efforts to reduce inequalities.

Finally, the framing of the core inequalities duty is narrowly focused on access to and outcomes from health services. The Bill misses an opportunity to recognise 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.¹² 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'.

Key questions

- 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?
- With levelling up and addressing health inequalities being a central objective for the NHS and government, how will 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?

Improving 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. Better use of data can also play an important role as the health and social care system focusses on the recovery, but currently our health and social care system is a long way from using data optimally.

The Bill outlines steps to clarify and improve data sharing between health and social care bodies. This should support efforts to coordinate services in ICSs. 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 and how the Bill might support this.

In social care, there are longstanding weaknesses in how data are used, collected, and shared.^{13,14} A lack of data on social care has affected the pandemic response.¹⁵ 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 programme¹⁶ has highlighted the sensitivities that surround any discussion about the collection and sharing of health and care data, and demonstrated the importance of trust.

Government must be transparent on how, and by who, data will be used and should engage with the public and health and social care professionals to build and maintain trust on this topic. 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

- Will the Bill enable the sharing of data beyond health and social care, particularly in relation to the wide range of other services provided by local authorities?
- 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?

Secretary of State powers

The Bill proposes giving wide ranging new powers to the Secretary of State. These changes lack rationale, are politically motivated, and warrant close scrutiny.

The powers would strengthen the health secretary's control over the day-to-day running of the NHS in England, including powers to direct NHS England – the national agency responsible for overseeing NHS planning and budgets – in relation to almost all its functions. They also include powers to intervene at any stage in service reconfigurations, such as decisions about merging or closing local hospitals. NHS leaders would be required to notify the health secretary about proposals to reconfigure services. And the Secretary of State will be able to 'retake' decisions already made by NHS leaders, as well as direct them to consider new service changes.

It is not clear how these changes will benefit patients – and they risk making things worse. Decisions about service changes are complex and evidence to inform them is often limited and disputed.^{17,18} Independent judgment has been used to help reduce ministerial involvement in contested decisions.¹⁹ Greater central intervention may also undermine the Bill's focus on giving power to local leaders to improve population health. Government should articulate clearly why they think these new powers are needed, what they plan to do with them, and what oversight will be in place to ensure decisions are made fairly and transparently.

Key questions

- 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?
- 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?

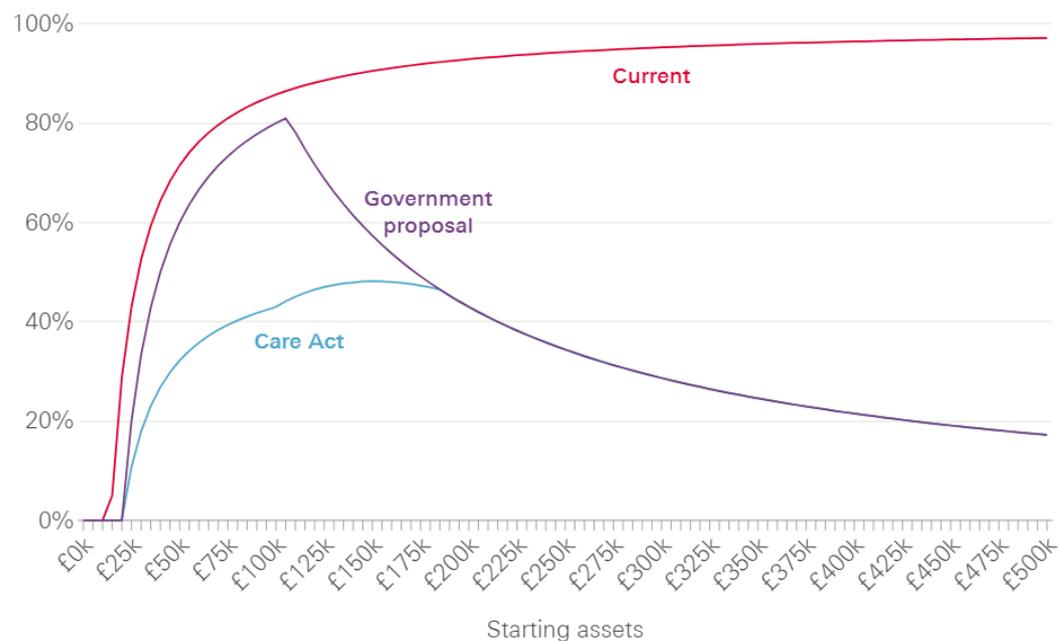
The social care cap

The Health Foundation welcomed government's plans to introduce a £86k cap on social care costs, supported by the Health and Care Levy. While the funding announced for social care still falls short of what is needed to stabilise the current system and deliver comprehensive reform, the original proposals would have provided people with greater certainty about the future.

In 2011, The Dilnot Commission recommended a cap on care costs of between £25k and £50k. The Care Act 2014 was passed to implement Dilnot's proposals, but successive governments have since failed to bring it into force. This Government's planned £86k cap is already less generous than under the Care Act – and its last-minute amendment to the Health and Care Bill (now Clause 140) further undermines its own ambition to protect people with lower assets from catastrophic care costs. By only counting private contributions towards the cap, and disregarding local authority contributions, those with wealth of less than £106k will be exposed to maximum care costs of almost twice the amount as under the Care Act. The Dilnot Commission considered this approach and rejected it as unfair.

The [chart](#) on page 7 shows people's maximum exposure to care costs. It compares the current status quo, the system under the Care Act and the Government's revised approach. Under the current system people can lose all but £14,250 of their assets before being eligible for publicly funded social care. For someone with £100k this represents 86% of their wealth. Under the Care Act, this would be reduced to 43%. But the Government's approach would result in the maximum loss of £80k – 80% of their assets. The proposals offer little protection against catastrophic costs for those with lower levels of wealth.

Maximum spend on care as proportion of starting assets, by starting assets



These changes are poorly conceived and a step in the wrong direction. They seem motivated by a desire to save money – but to do so by taking protection away from poorer homeowners.

Key questions

- What is the rationale behind government's decision to count only private contributions towards the £86k social care cap? Who will benefit from this change?
- What will the impact of the changes be for those with lower assets? Has any consideration been given to what further support might be needed to mitigate this impact?

Further reading

To read further analysis of proposals within the Bill, please visit our [webpage on the Health and Care Bill](#) or see our [Briefing for the Commons Public Bill Committee](#).

If you have any questions on the content of this briefing, please email Caitlin Law, External Affairs Officer at the Health Foundation on caitlin.law@health.org.uk

Appendix

Amendment to address workforce shortages

This amendment was negated on division in the House of Commons.

Clause 34, page 42, line 12, leave out from beginning to end of line 17 and insert—

“(1) The Secretary of State must, at least once every two years, lay a report before Parliament describing the system in place for assessing and meeting the workforce needs of the health, social care and public health services in England.

(2) This report must include—

- (a) an independently verified assessment of health, social care and public health workforce numbers, current at the time of publication, and the projected workforce supply for the following five, ten and 20 years; and
- (b) an independently verified assessment of future health, social care and public health workforce numbers based on the projected health and care needs of the population for the following five, ten and 20 years, consistent with the Office for Budget Responsibility long-term fiscal projections.

(3) NHS England and Health Education England must assist in the preparation of a report under this section.

(4) The organisations listed in subsection (3) must consult health and care employers, providers, trade unions, Royal Colleges, universities and any other persons deemed necessary for the preparation of this report, taking full account of workforce intelligence, evidence and plans provided by local organisations and partners of integrated care boards.”

Amendment to strengthen reporting on health inequalities (NC57)

This amendment was debated in the House of Commons but not added to the Bill.

To move the following Clause—

“NHS England’s duty as to reducing inequalities

Section 13G of the National Health Service Act (duty as to reducing inequalities), is amended by the addition of the following subsections—

“(2) NHS England must publish guidance about the collection, analysis, reporting and publication of performance data by relevant NHS bodies with respect to factors or indicators relevant to health inequalities.

(3) Relevant NHS bodies must have regard to guidance published by NHS England under this section.

(4) In this section “relevant NHS bodies” means—

- (a) NHS England,

- (b) integrated care boards,
- (c) integrated care partnerships established under section 116ZA of the Local Government and Public Involvement in Health Act 2007,
- (d) NHS trusts established under section 25, and
- (e) NHS foundation trusts.””

¹ Baxter S, Johnson M, Chambers D, Sutton A, Goyder E, Booth A. The effects of integrated care: a systematic review of UK and international evidence. *BMC Health Serv Res.* 2018;18:350.

² Alderwick H, Hutchings A, Briggs A, Mays N. The impacts of collaboration between local health care and non-health care organizations and factors shaping how they work: a systematic review of reviews. *BMC Public Health* 2021 ;21:753.

³ Winters S, Magalhaes L, Kinsella EA, Kothari A. Cross-sector provision in health and social care: an umbrella review. *Int J Integr Care.* 2016;16:10.

⁴ Perkins N, Smith K, Hunter DJ, Bamba C, Joyce K. ‘What counts is what works’? New Labour and partnerships in public health. *Polit Policy.* 2010;38:101-17.

⁵ Mackie S, Darvill A. Factors enabling implementation of integrated health and social care: a systematic review. *Br J Community Nurs.* 2016;21:82-7.

⁶ Fulop N, Protopsaltis G, Hutchings A, et al. Process and impact of mergers of NHS trusts: multicentre case study and management cost analysis. *BMJ.* 2002;325:246.

⁷ Helen Whately, House of Commons written answer, 23 July 2020 (UIN 71059). <https://questions-statements.parliament.uk/written-questions/detail/2020-07-08/71059>.

⁸ Suleman et al., The Health Foundation, *Unequal pandemic, fairer recovery: The COVID-19 impact inquiry report*, July 2021 (<https://health.org.uk/publications/reports/unequal-pandemic-fairer-recovery>).

⁹ Thorlby et al., The Health Foundation, *The NHS Long Term Plan and COVID-19: Assessing progress and the pandemic’s impact*, September 2021

<https://www.health.org.uk/publications/reports/the-nhs-long-term-plan-and-covid-19>.

¹⁰ NHS England, *Implementing phase 3 of the NHS response to the COVID-19 pandemic*. 7 August 2020 (<https://www.england.nhs.uk/wp-content/uploads/2020/08/implementing-phase-3-of-the-nhs-response-to-covid-19.pdf>), p.2.

¹¹ NHS England. NHS oversight metrics for 2021/22. NHS England; 2021 (<https://www.england.nhs.uk/wp-content/uploads/2021/06/B0693-nhs-oversight-metrics-for-2021-22.pdf>).

¹² Reed S, et al. *Building healthier communities: the role of the NHS as an anchor institution*. The Health Foundation; 2019 (www.health.org.uk/publications/reports/building-healthier-communities-role-of-nhs-as-anchor-institution).

¹³ Office for Statistics Regulation. Adult social care statistics in England. OSR. 2020.

<https://osr.statisticsauthority.gov.uk/publication/report-on-adult-social-care-statistics-in-england/>.

¹⁴ Hanratty B, Burton JK, Goodman C, Gordon AL, Spilbury K. Covid-19 and lack of linked datasets for care homes. *BMJ.* 2020; 369: m2463.

¹⁵ Dunn P, Allen L, Alarilla A, Grimm F, Humphries R, Alderwick H. Adult social care and COVID-19 after the first wave: assessing the policy response in England. London: Health Foundation. 2021.

<https://www.health.org.uk/publications/reports/adult-social-care-and-covid-19-after-the-first-wave>.

¹⁶ NHS Digital. General Practice Data for Planning and Research (GDPR). <https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/general-practice-data-for-planning-and-research>.

¹⁷ Imison C, Sonola L, Honeyman M, Ross S. The reconfiguration of clinical services: what is the evidence? King’s Fund, 2014.

¹⁸ Fulop NJ, Ramsay AIG, Hunter RM, et al. Evaluation of reconfigurations of acute stroke services in different regions of England and lessons for implementation: a mixed-methods study. *Health Services and Delivery Research* 2019;7.

¹⁹ Timmins N. Glaziers and window breakers: former health secretaries in their own words Health Foundation. 2020. <https://www.health.org.uk/publications/reports/glaziers-and-window-breakers>.