Briefing for Peers: Health and Care Bill, Report Stage

Tuesday 1 March 2022

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, encouraging collaboration to improve care makes sense and goes with the grain of recent NHS policy. We also welcome the government's proposed amendments to encourage a data driven approach to narrowing health inequalities.

But the Bill misses opportunities to support the health and care system to recover from the impact of the pandemic across two key areas: workforce shortages and data sharing. There are also some aspects of the Bill that lack rationale and 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 a summary of our analysis of the key proposals within the Bill. We explore the potential implications of the changes, providing recommendations for how the Bill should be amended during Report Stage in the House of Lords.

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. 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 the government to create a better system for workforce planning, yet the Bill currently falls far short of the action needed. Clause 35 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. Crucially, this fails to address whether the system is training, educating and retaining enough people to deliver services now and in the future.

We are supporting the amendment to clause 35 tabled by Baroness Cumberlege, which would require 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 are disappointed that the amendment has so far not been accepted by the government, despite support from over 90 health and care organisations – and the Health and Social Care Select Committee. During Committee Stage in the House of Lords, Lord Kamall pointed to Health Education England's forthcoming Framework 15, which will review long term strategic trends for the health and social care workforce. However, Framework 15 will not solve the glaring data gap on health and care staffing numbers – which is crucial to inform strategic workforce planning decisions.

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.[1] Smarter long-term investment in the workforce presents opportunities to limit costs on short-term spending when services come under pressure.

Key questions

- Will the Minister 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.[2] Progress on national NHS commitments related to reducing health inequalities has been slow in recent years,[3] and NHS England has urged local systems to accelerate action to tackle inequalities after the pandemic.[4] 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 long read, when first introduced in the House of Commons the Bill's original provisions relating to health inequalities amounted 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 was 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 recent rapid review of ethnic inequalities in health care, published by the NHS Race and Health Observatory, has since highlighted the importance of better statistics to support monitoring and research.

Amendment on health inequalities data

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.[5] To help drive more action and enable better tracking of progress across different areas, we proposed an amendment to require NHS England to publish guidance on collecting, analysing, reporting and publishing data on all factors or indicators relevant to health inequalities (see appendix). This amendment was selected for debate at Report Stage in the House of Commons and Committee Stage in the Lords but was not put to a vote.

Following committee stage, the government proposed a related amendment (see appendix) requiring NHS England to publish a statement describing the powers of NHS trusts, foundation trusts and Integrated Care Boards to collect, analyse, and publish information relating to inequalities in 'people's access to, outcomes from and experience of health services'. The amendment specifies that NHS England will also be required to outline its view on how those powers should be exercised as part of the statement. In turn, those bodies will be required to review the extent of their compliance with NHS England's view in their annual reports.

While this doesn't precisely follow the amendment proposed by the Health Foundation, the government's concession is very welcome and should help to support a data driven approach to narrowing health inequalities. The amendment requires NHS bodies (ICBs, NHS Trusts and NHS Foundation Trusts) to publish regular data on inequalities and state the extent to which they have complied with the NHS's view on the data powers.

We are now seeking clarity about how and to what extent NHS England will be expected to exercise this new power. In particular, the amendment – and national policy and planning guidance – is focused on requiring NHS bodies to report on inequalities within localities and services. Will the DHSC or NHS England seek to compile national-level data about inequalities between different parts of England, as well as the inequalities within them? And, if so, will Ministers commit to publishing such data to allow progress in tackling inequalities and to enable comparisons across different areas?

Amendment on the triple aim

Another key area of the Bill that requires strengthening relates to the new 'triple aim' duty 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. When first introduced, the triple aim duty did not explicitly mention health inequalities.

The government has now proposed an amendment to incorporate health inequalities into the triple aim. While this does not amend the triple aim itself, it adds new subsections making clear that (a) and (b) of the triple aim include a reference to health inequalities. We welcome

this proposed amendment. By explicitly referencing inequalities in the triple aim duty, a clearer signal will be sent to health and care leaders about its importance as a goal, with NHSE, ICBs and Trusts required to consider the impact of their decisions on health inequalities.

Key questions

- With levelling up and addressing health inequalities being a central objective for the NHS and government, what non-legislative action will they take to reduce inequalities?
- Will the DHSC or NHS England seek to compile national-level data about inequalities between different parts of England, as well as the inequalities within them?
- And, if so, will Ministers commit to publishing such data to allow progress in tackling inequalities and to enable comparisons across different areas?

The social care cap

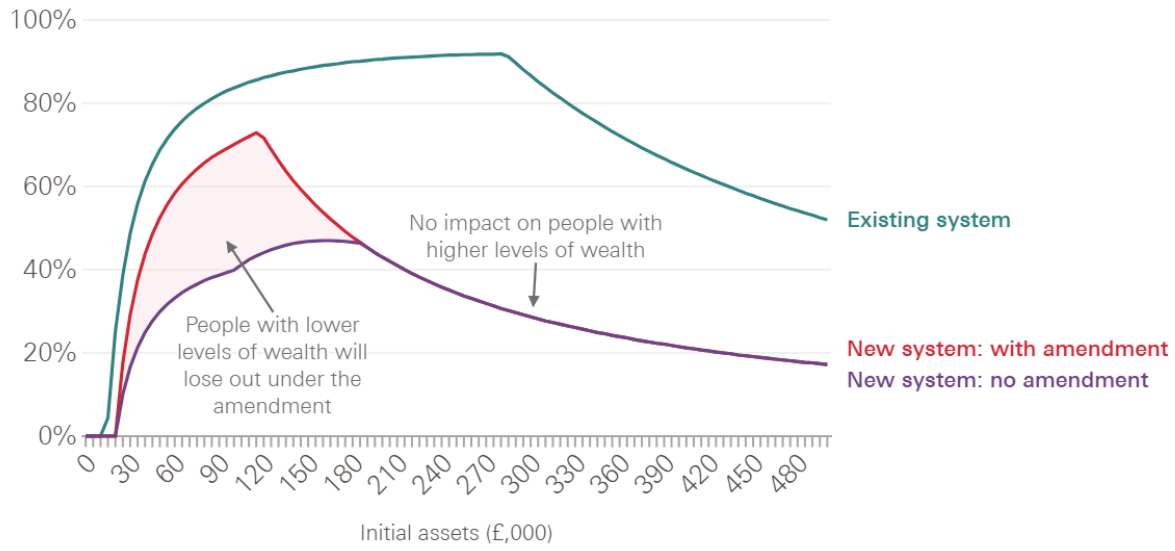
The Health Foundation welcomed the government's plans to introduce a £86k cap on social care costs and to widen the means-test , supported by the Health and Care Levy. While the funding announced for social care falls well short of what is needed to stablise the current system and deliver comprehensive reform, the cap will protect people against the risk of very high care costs and provide them 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 155) 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 below shows the proportion of starting wealth spent on a 'worst case' care journey, by level of wealth. The amendment makes no difference to people with starting wealth of more than £186,000 because they will not receive means-tested support. This is because they will hit the £86,000 cap before their assets fall to below £100,000 (the starting level for means-tested support). Those with initial wealth below this will receive means-tested support when their assets are below £100,000, and so will be affected by the amendment.

When we divide the population aged 65 and older into fifths according to their wealth, those facing the biggest loss from the amendment are in the second poorest fifth (with wealth per person of between £83,000 and £183,000). For this group, the government's plans would mean that 10 years in residential care would require spending an additional 10% of assets (or around £12,000), on average. This compares with almost nothing extra for people in the wealthiest 40% (those with assets of more than £298,000).

Care cost spend as a percentage of initial assets, under 'worst case' scenario



Source: Authors' calculations, Does the cap fit? • Note: Assumes a 10-year residential care journey costing £700 per week. Of this £700 weekly cost, £200 per week living costs are assumed to be met from income and the remaining cost is assumed to be met from assets or means-tested support, as per the relevant system rules.

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 older homeowers and adults of working age with care needs.

We are disappointed that calls for clause 155 to be amended or removed from the Bill have so far been rejected in the House of Commons. Our new blog summarises independent analysis with the Institute for Fiscal Studies, assessing how this would affect different groups, aiming to inform debate on this topic.

Key questions

- What is the government's assessment of its decision to count only private contributions towards the £86k social care cap? What are the cost savings and which groups will they come from?
- What will the impact of the changes be for those of working age with care needs and of older people with modest levesl of wealth? Has any consideration been given to what further support might be needed to mitigate this impact?

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.[6,7] Making collaboration work also depends as much on culture, management, resources, and other factors as it does on NHS rules and structures.[8,9,10] 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 organised – and government’s new white paper on integration between health and social care proposes additional changes at a ‘place’ level that may cut across the intended role of ICBs 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. [11] 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 with 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?

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.[12,13] A lack of data on social care has affected the pandemic response.[14] 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[15] 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.[16,17] Independent judgment has been used to help reduce ministerial involvement in contested decisions.[18] 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?

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, and was debated then withdrawn during Committee Stage in the House of Lords.

Page 42, leave out lines 14 to 19 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."

Amendments to strengthen reporting on health inequalities

Proposed government amendment

Page 3, after clause 6 insert the following new Clause—

"Information about inequalities

(1) The National Health Service Act 2006 is amended as follows.

(2) After section 13S insert—

"13SA Information about inequalities

(1) NHS England must publish a statement setting out—

(a) a description of the powers available to relevant NHS bodies to collect, analyse and publish information relating to—

(i) inequalities between persons with respect to their ability to access health services; (ii) inequalities between persons with respect to the outcomes achieved for them by the provision of health services (including the outcomes described in section 13E(3)); and

(b) the views of NHS England about how those powers should be exercised in connection with such information.

The Health Foundation original amendment

Clause 3, page 2, line 19, at end insert—

"(3A) In section 13G (duty as to reducing inequalities), after "the provision of health services." insert—

"(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] Helen Whately, House of Commons written answer, 23 July 2020 (UIN 71059). https://questions-statements.parliament.uk/written-questions/detail/2020-07-08/71059.
[2] 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).
[3] 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.
[4] 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.
[5] 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).
[6] 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.
[7] 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.
[8] 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.
[9] Perkins N, Smith K, Hunter DJ, Bambra C, Joyce K. 'What counts is what works'? New Labour and partnerships in public health. Polit Policy. 2010;38:101-17.
[10] Mackie S, Darvill A. Factors enabling implementation of integrated health and social care: a systematic review. Br J Community Nurs. 2016;21:82-7.
[11] 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.
[12] 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/.
[13] Hanratty B, Burton JK, Goodman C, Gordon AL, Spilsbury K. Covid-19 and lack of linked datasets for care homes. BMJ. 2020; 369: m2463.
[14] 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.
[15] NHS Digital. General Practice Data for Planning and Research (GPDPR). https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/general-practice-data-for-planning-and-research.
[16] Imison C, Sonola L, Honeyman M, Ross S. The reconfiguration of clinical services: what is the evidence? King 's Fund, 2014.
[17] 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.
[18] 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.