The King's Fund

Ideas that change health care

Briefing

Health and Care Bill: House of Lords Report stage

Summary

The King's Fund supports much of the Health and Care Bill, however there are four priority areas we believe require amendment.

- **Reconfiguration powers:** Extensive new powers for the Secretary of State to intervene in local service reconfigurations bring the risk of a decision-making log jam and dragging national politics into local decisions over services. These powers should be removed from the Bill or, at the very least, safeguards should be added to limit the circumstances in which the Secretary of State can intervene, require appropriate consultation, and introduce a time limit on decision-making.
- **Powers to direct NHS England:** To provide confidence in the operational and clinical independence of the NHS, parliament should seek further safeguards over the new powers for the Secretary of State to direct NHS England.
- **Workforce:** The measures in the Bill to address chronic staff shortages remain weak. A new duty should be added to the Bill, requiring the regular publication of independently verified projections of the current and future workforce required to deliver care to the population in England
- **Cap on social care costs:** The change to the social care cap is regressive and will mean that the main beneficiaries of the government's reforms will be people with higher assets, while the benefit to people with low to moderate assets will be marginal. To protect people with lower assets from catastrophic costs, the change to the care cap should be removed from the Bill.

Part 1: Health services in England: integration, collaboration and other changes

Integration and collaboration

The measures in this Bill will support greater collaboration between the NHS, local authorities, the voluntary and community sector, and other partners with the aim of improving population health. Many of the proposals within this Bill were specifically requested by NHS leaders, are widely supported by stakeholders, and build on existing work to integrate care.

New structures

At the heart of the changes to support integration is the formalisation of integrated care systems (ICSs), which already exist in all parts of England, and which, under this legislation, will be placed on a statutory footing. Each ICS will be made up of two parts: an integrated care board (ICB) and an integrated care partnership (ICP). ICBs will be tasked with the commissioning and oversight of most NHS services and will be accountable to NHS England for NHS spending and performance. ICBs will be made up of a chair, chief executive, representatives of different parts of the NHS in that area and a local authority representative. ICPs will bring together a wider range of partners to develop a plan to address the broader health, public health, and social care needs of their local population.

The exact membership of ICBs and ICPs should not be prescribed in either legislation or national policy documents. A key advantage of these reforms is that the new structures allow for local flexibility. We welcome the continued permissive approach as it gives areas the freedom to construct these new bodies in a form that best matches the needs of the communities they serve and builds on existing local relationships and partnerships. The government amendment requiring the skills, knowledge and experience of ICB members to be kept under review is a welcome step. It will help ensure each ICB has appropriate expertise while also protecting the flexibility needed in ICB membership.

To help make sense of the proposed new structures, The King's Fund has produced a visual guide to how the new structures are intended to function (The King's Fund 2021).

The importance of partnership at the 'place' level

The 2021 White Paper that preceded this legislation (*Integration and innovation: working together to improve health and social care for all*, Department of Health and Social Care 2021) emphasised the primacy of joint working at the 'place' level, which is a smaller footprint than an ICS, often based on that of a local authority. In February 2022, government set out further plans for integration and collaboration at 'place' in an integration White Paper (Department of Health and Social Care 2022).

We support this emphasis on 'place', as experience suggests that much of the heavy lifting of integration will be driven by organisations collaborating over smaller geographies within ICSs.

There is a need for flexibility in these local, place-based joint-working arrangements. For this reason, the Bill does not include legislative requirements to collaborate at the level of 'place', but it does make clear that ICBs will be able to exercise their functions through place-based committees (Clause 62).

We are pleased that the legislation avoids a one-size-fits-all approach to arrangements at place level. We support the permissive approach set out in the Bill that will allow places the freedom to respond to the needs of their local populations (Charles et al 2021).

Previous reforms have over-specified local arrangements, so we welcome the permissive and flexible approach set out in the Bill.

Secretary of State powers to intervene in local service reconfigurations

As it stands, the Bill (Clause 40; Schedule 6) would give the Secretary of State sweeping powers to intervene earlier in decisions about changes to local services. These powers will expose ministers to intense lobbying to override NHS clinical and operational decisions, introduce the risk of political calculations trumping clinical judgement and lead to a decision-making log jam.

The Bill would require the Secretary of State to be notified when an NHS body is aware of circumstances that it thinks are likely to result in the need for service change.

It remains unclear what scale or scope of service change would require the NHS to notify the Secretary of State. The explanatory notes (House of Lords 2021, paragraph 99) state that this new power is 'intended to be used in cases which are complex, a significant cause for public concern, or where Ministers can see a critical benefit to taking a particular course of action'. However, this is not explicit on the face of the Bill. There is potential for a large number of service-change decisions to land on the Secretary of State's desk, risking a decision-making log jam and placing a significant burden on local and national bodies as they wait for decisions. For reforms that are intended to reduce bureaucracy, this could create a significant new bureaucratic burden.

Ministers have argued that these new powers are necessary to ensure democratic oversight of health service decisions. However, the existing system allows appropriate democratic oversight and for contentious service change decisions to be resolved. The wholesale upheaval of this system and introduction of sweeping new powers for the Secretary of State is not justified.

We have argued that these powers should be stripped from the Bill. At the very least, safeguards should be introduced to limit their use. These safeguards should include clarity on the face of the Bill that the Secretary of State can only intervene in substantial and complex reconfigurations, a requirement to consult relevant bodies, and a requirement for the Secretary of State to outline how any reconfiguration decision they make is in the public interest. The power for the Secretary of State to act as a catalyst by instigating a

reconfiguration should be removed and a time limit for the Secretary of State to reach a decision about a reconfiguration should be included.

New powers for the Secretary of State to intervene in reconfigurations risk the unhelpful politicisation of local service-change decisions and a decision-making log jam. These new powers should be stripped from the Bill, or at the very least, safeguards should be introduced to limit their use.

Secretary of State powers to direct NHS England

Since the 2012 reforms, the scope of NHS England's work has increased significantly, most recently with the announcement that Health Education England, NHSX and NHS Digital will also be folded into NHS England. With so much decision-making now concentrated in NHS England, we do not disagree about the need for a power of direction or appropriate powers to match the political responsibility the Secretary of State has for health and care services (and the public expectations that comes with). However, we do not think this power should extend to intervening in NHS England's operational independence. This swings the pendulum too far in the other direction.

These new powers are part of a pattern visible throughout the Health and Care Bill that sees ministers given greater power without adequate checks and balances. The Delegated Powers and Regulatory Reform Committee recently concluded that the scale of powers being moved from parliament to government by this Bill 'offends against the democratic principles of parliamentary scrutiny' (Delegated Powers and Regulatory Reform Committee 2021).

The Minister has acknowledged that government 'must ensure that there are safeguards and transparency mechanisms in place' (Hansard), but the limits currently on the face of the Bill do not go far enough.

To protect NHS England's operational and clinical independence, we believe the Bill should be amended to prevent the Secretary of State from intervening on certain issues including financial allocations to ICSs and other bodies, procurement decisions, or forcing NHS England to use its powers against individual NHS organisations. In addition, any direction given under these powers should be time-bound, and require the Secretary of State to justify why the direction is in the public interest.

Parliament should seek safeguards regarding the scope of the new powers of the Secretary of State to direct NHS England, including an exemption so ministers cannot direct the allocation of funds to local systems.

Health and care workforce

The health and care workforce crisis will be the rate-limiting factor in reducing the NHS elective care backlog and delivering the ambitions behind the reforms in this Bill. Years of poor planning, weak policy and fragmented responsibilities for the workforce mean that staff shortages have become endemic.

Clause 35 of the Bill places a duty on the Secretary of State to report at least every five years on the system for assessing and meeting workforce needs. Compared to the scale of the workforce crisis, this is weak and inadequate.

Alongside more than 90 organisations (Royal College of Physicians 2021), The King's Fund has called for this requirement to be strengthened by mandating the regular publication of independently verified workforce projections. The Health and Social Care Committee has also recommended that the Bill include a requirement for objective, transparent and independent reporting on workforce shortages and future staffing requirements (House of Commons Health and Social Care Committee 2021b). For such projections to be credible, it will be important that they are independently verified and consistent with the Office for Budget Responsibility's long-term fiscal projections.

Ministers have dismissed the need for such projections, pointing to a planned update to 'Framework 15', Health Education England's 15-year strategic framework for workforce planning. This is inadequate. Previous iterations of the framework first published in 2014 and 2017 (Health Education England 2017b) have not quantified the workforce numbers needed, and the Secretary of State was recently unable to confirm that the revised framework will include workforce projections (House of Commons Health and Social Care Committee 2021a).

Although an amendment requiring the publication of workforce projections tabled by the chair of the Health and Social Care Committee was defeated at Report stage in the House of Commons, it received considerable support from across the House. Many peers, including several with experience working at the highest levels of the health service, spoke in favour of such an amendment at the Bill's Committee Stage in the House of Lords and support the need to hold the government to account on workforce planning.

There is a long and growing list of authoritative voices supporting the amendment tabled by Baroness Cumberlege, which would require the biannual publication of independently verified future workforce projections. The duty would provide the much-needed political impetus to finally get to grips with one of the most significant challenges facing health and care services.

We urge parliament to support the amendment that will require the regular publication of independently verified projections of future demand and supply of the health and social care workforce in England.

Tackling health inequalities

The pandemic has exposed deep and widening health inequalities between different population groups and geographical areas. Disparities in access to care are starting to emerge, with people living in the most-deprived areas in England nearly twice (1.8 times) as likely to experience a wait of more than one year for hospital care than those who live in the least-deprived areas (Holmes and Jefferies 2021).

For this reason, we welcome the government amendments which make clear that tackling health inequalities is integral to the new 'triple aim' intended to guide NHS decision-

making. The intention behind the 'triple aim' is not to burden NHS organisations with onerous reporting requirements but to provide a guiding light and align them behind a shared set of system-wide goals.

In bringing these amendments, the movement will help ensure NHS efforts to address inequalities moves from a 'nice to have' to a 'must do'.

Part 6: Miscellaneous

Cap on social care costs

Clause 155 of the Bill amends the Care Act 2014 to fundamentally change the cap-and-floor model of social care funding enshrined in the Act. The change means that any local authority contribution towards paying for a person's care would no longer be counted towards the cap on their total costs. This means that poorer people will be exposed to the same social care costs as the very wealthiest in society, leaving many of them at risk of having to sell their home to fund their care, despite the government manifesto commitment that no-one would be forced to do this. Recent analysis shows that the impact of this change will be felt most acutely in less wealthy parts of England, such as the North East, Yorkshire and the Humber and the Midlands (Tallack and Sturrock 2022).

Ministers have justified the change by saying that the new system will be more generous than the current one. While it is true that the majority of people will be better off under the reformed system – which is being funded through the increase in National Insurance embodied in the Health and Social Care Levy – the main beneficiaries will be people with higher assets, while the benefits for people with low to moderate assets will be marginal, and as a result of the changes to the means tests thresholds, not the cap.

The change to the social care cap is regressive and runs counter to the government's ambition of 'levelling up'. To ensure those people with low to moderate assets are protected from catastrophic costs, the clause 155 change to the care cap should be removed from the Bill.

Conclusion

The King's Fund supports the main thrust of the Health and Care Bill which will remove clunky competition rules and enable greater collaboration between health and care organisations to deliver integrated care. We also support the permissive approach that will allow local areas to decide how they best work together to meet the needs of their communities. Government amendments making it clear that tackling inequalities should be central to NHS decision-making are another positive change introduced in this Bill.

However, there are aspects of the Bill that we believe should be changed. Notably, the regressive change to the cap on social care costs should be removed from the Bill. We strongly believe the Bill should be amended to require the regular publication of health and care workforce projections and enable a more strategic approach to meeting health and care staffing needs. To ensure service change decisions are based on patients' needs

and not political calculations, the new powers for the Secretary of State to intervene in reconfigurations should be stripped from the Bill, or at the very least greater safeguards put in place to limit their use. Similarly, we believe that the new power for the Secretary of State to direct NHS England require safeguards to ensure the clinical and operational independence of the NHS.

About The King's Fund

The King's Fund is an independent charity working to improve health and care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible health and care is available to all.

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