The King's Fund

Ideas that change health care

Briefing

Health and Care Bill
House of Commons Second Reading

Key messages

- This legislation will remove clunky competition rules and make it simpler for health and care organisations to work together to deliver more joined-up care to the increasing number of people who rely on support from multiple different services.
- The success of these reforms will critically depend on how they are implemented locally. Ministers therefore need to do more to set out a compelling case for what the changes will achieve and the difference they will make to patients and service users.
- The reforms to integrate health and care services build on the vision set out in the NHS Long Term Plan and are strongly supported by health and care stakeholders. Many of the changes have been requested by health and care leaders who currently face legislative barriers to joining up care.
- While any reform brings the risk of disruption, not pressing ahead with these changes would potentially be more disruptive as preparations to implement them are well under way. It would also leave in place elements of the market-based approach to health and care that has led to today's fragmented system.
- Government and parliament should resist the urge to specify in legislation additional granular detail about how improved collaboration should be achieved at 'place' level. Local flexibility is critical for effective joint working.
- Extensive new powers for the Secretary of State to intervene in local service reconfigurations bring the risk of political expediency trumping clinical judgement and a decision-making log jam – a far cry from the government's stated ambition to reduce bureaucracy.
- The Covid-19 pandemic has exposed deep and widening health inequalities. To ensure addressing this is given sufficient priority across the system, reducing health inequalities should be incorporated within the new 'triple aim'.
- The measures in the Bill to address chronic staff shortages remain weak. A new duty to publish regular workforce supply-and-demand projections should be added to the Bill.

- Reforming health services while leaving the social care sector in crisis is a recipe for disaster. The government should come forward with its long-overdue plan to reform social care without further delay.

Introduction

The Health and Care Bill introduces new measures to promote and enable collaboration in health and care, building on earlier recommendations made by NHS England and NHS Improvement. The Bill also contains new powers for the Secretary of State over the health and care system, and targeted changes to public health, social care, and quality and safety matters. In this briefing, we focus on the bulk of the Bill, which deals with the NHS and its relationships to other parts of the system, including the Secretary of State.

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

Integration and collaboration

We strongly welcome the move away from the old legislative focus on competition as the driver of improvement in health and care towards a new model of collaboration and integration. We have long championed the need for integrated care to support the increasing number of people living with multiple conditions who rely on the support of different services. Many of the proposals were specifically requested by NHS leaders, are widely supported by stakeholders, and build on existing work to integrate care.

While legislation can remove some barriers to collaboration, it is not possible to legislate for collaboration and co-ordination of local services. This requires changes to the behaviours, attitudes and relationships of staff and leaders right across the health and care system, including within national bodies. This makes implementation critically important, especially as the legislation rightly leaves so much to local (and national) discretion. Ministers therefore need to do more to set out a compelling case for what these reforms should achieve and the difference they will make to patients and service users to set the direction for implementation.

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 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. ICPs will bring together a wider range of partners, not just the NHS, to develop a plan to address the broader health, public health, and social care needs of their local population.

The ICB membership must include as a minimum a chair (appointed by NHS England and approved by the Secretary of State), chief executive, an NHS provider representative

(nominated by local NHS trusts), a primary care representative (nominated by local GPs), and a local authority representative (nominated by local authorities). The membership and ways of working of ICPs has been left very flexible. We welcome this permissive approach as it gives areas the flexibility to build on existing local relationships and partnerships, but it does speak to an asymmetry between ICBs and ICPs, the former being subject to more granular legal stipulations.

Relationship between bodies

We believe ICSs should primarily look out to the needs of their local population, rather than looking up to the demands of national bodies. This shift in focus cannot be legislated for and underlines the importance of culture, behaviour change and the careful implementation of these proposals more generally.

There will be multiple plans and strategies in each ICS and there is a risk of confusion about how these inter-relate. At the more local 'place' level, there will be joint strategic needs assessments as well as health and wellbeing strategies (both produced by existing health and wellbeing boards), while at the ICS level, there will be an integrated care strategy (developed by the ICP) and a five-year forward plan (developed by the ICB and to be updated annually). How well different bodies and their plans work in practice will depend on the quality of relationships and leadership in the area, the functionality of the existing health and wellbeing boards, and the clarity of vision/leadership locally. There will be a need to provide support to help ICSs clearly demarcate the goals and purposes of the various strategies and plans they will have in operation.

The importance of partnership at the 'place' level

The White Paper that preceded this legislation (Department of Health and Social Care 2021) emphasised the primacy of joint working at the 'place' level, which is a smaller footprint than that of an ICS, often based on that of a local authority. We support this emphasis, as experience suggests that much of the heavy lifting of integration will be driven by organisations, including the voluntary and community sector, collaborating over smaller geographies within ICSs.

The White Paper emphasised the need for local flexibility in these more local, place-based joint-working arrangements, hence the intention to encourage collaboration at the more local level does not feature heavily in the legislation, other than to make clear that ICBs will be able to exercise their functions through place-focused committees.

We are pleased that the legislation avoids a one-size-fits-all approach to the local arrangements. We encourage the government and parliament to resist the urge to specify in legislation granular detail about how improved collaboration should be achieved, as this would risk undermining the local flexibility that is critical for integrated working.

It is important that a permissive approach to place-based arrangements survives the Bill's passage through parliament and that places have the freedom to respond to the needs of their local populations, rather than following a one-size-fits-all statutory approach (Charles *et al* 2021).

Removing competition

A reduced focus on competition between providers is welcome. Health care in England has never been a truly competitive market and evidence for the benefits of competition is equivocal at best. As we have seen throughout the Covid-19 pandemic, collaboration between organisations is key to driving innovation and improvement.

Many clauses in the legislation go with the grain of existing health and care strategy and policy. Since the publication of the NHS Five Year Forward View, the NHS in England has been moving away from competition and policy based on organisation by default, to collaboration and policy based on system by default.

One of the changes is the reduction in compulsory competitive procurement. However, many areas – including non-clinical services – will remain within the scope of existing procurement processes. This will help to ensure appropriate checks and balances on the procurement of external services such as catering and management consultancy.

While some have raised concerns that this legislation will allow contracts to be awarded to new providers without sufficient scrutiny, we believe the greater risk is that contracts are automatically handed out to incumbent providers. There should be measures to mitigate this risk and encourage a diversity of providers, including the voluntary and community sector, which plays a vital role in delivering health and care services.

Changes to payments

To further reduce bureaucracy and enable collaboration, the legislation increases the flexibilities in the pricing process through which health care providers are paid. The changes would mark a welcome opportunity to move away from activity-based payments towards a model that facilitates greater collaboration and a focus on population health.

Secretary of State powers to intervene in local service reconfigurations

As it stands, the Bill would give the Secretary of State sweeping powers to intervene earlier in decisions about changes to local services. Such broad powers create the risk of political expediency trumping clinical judgement in these decisions.

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 reconfiguration. This could lead to any service change in the NHS potentially landing on the Secretary of State's desk, risking a decision-making log jam and placing a significant burden on local and national bodies awaiting decisions. Of particular concern is the intention to use these powers where there may be a temporary change to service provision to manage immediate operational pressures. For reforms that are intended to reduce bureaucracy, this could create one of the biggest bureaucratic burdens in recent memory.

Secretary of State powers to direct NHS England

The Bill recognises the work already undertaken to bring together NHS England and NHS Improvement into a single organisation and places it on a statutory footing by abolishing Monitor and the NHS Trust Development Authority (the two bodies who work together under the name NHS Improvement) and transferring their functions to NHS England.

In recognition of the increased range of functions this newly merged body will have, the Bill includes measures to ensure the Secretary of State has greater power over NHS England. The government has, however, stated an intent to maintain the clinical and day-to-day operational independence of the NHS.

Since the 2012 reforms, many arm's length-body powers have been consolidated into NHS England, and there are problems with the current NHS Mandate process by which ministers can direct NHS England. This provides a rationale for making changes to the Mandate to increase its flexibility.

However, the Bill also provides the Secretary of State with a general power to direct NHS England outside the Mandate. While the Bill specifies some limits to how the new power of direction over NHS England could be used, it is still very broad. To protect the operational and clinical independence of NHS England, much more specificity should be provided on the scope of these powers, the circumstances in which they might be used and the oversight and scrutiny in place to review how they are used.

Health and care workforce

As the government's manifesto recognised, the best way to improve the NHS and meet rising demand for health care is to invest in its most important asset – its people. Before the pandemic, staffing shortages were endemic, chronic excessive workloads were commonplace and levels of stress, absenteeism and turnover worryingly high (NHS England and NHS Improvement 2020). Many staff will emerge from the past year physically and mentally exhausted and in need of time and support to recover. Yet the measures in the Bill relating to the workforce remain weak.

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. The very fact that this system even needs to be explained indicates it is not working well. As drafted, there is no requirement for the report to include projections for future workforce demand and supply and the requirement to publish a report every five years is not sufficient. For example, the current Secretary of State could wait until 2026 to produce such a report.

Alongside a number of other organisations, we have called for a clause to mandate Health Education England to publish regular, independently verified projections of future demand and supply of the health care workforce in England (Charlesworth *et al* 2021). The Health and Social Care Committee has also recommended that the Bill include the requirement for objective, transparent, and independent reporting on workforce shortages and future staffing requirements (House of Commons Health and Social Care Committee 2021).

Such an amendment would be a powerful signal of intent. However, it is worth being clear that, on its own, it would not be enough to tackle the workforce crisis and must go hand in hand with a fully funded workforce strategy that addresses staff shortages, boosts retention by improving working cultures and includes a renewed commitment to providing compassionate and inclusive leadership.

Tackling health inequalities

The pandemic has exposed deep and widening health inequalities between different population groups and geographical areas. The Bill extends the current duties in the 2012 Act to 'have regard to the need to reduce inequalities' to ICBs. While this is welcome, these duties have not led to an increased focus on inequalities and extending this to ICBs will not make a meaningful difference on its own. To address this, reducing inequalities should be given a much higher priority in NHS performance-management and improvement approaches so that it moves move from being a 'nice to have' to a 'must do' (Robertson *et al* 2021).

The Bill introduces a new duty on NHS organisations to have regard to the 'triple aim' of better health and wellbeing, improving the quality of services and making efficient use of resources. The purpose of this is to align NHS organisations behind a shared set of system-wide goals. To ensure it is given sufficient priority across the system, this duty should be amended to incorporate reducing health inequalities within the triple aim.

Part 3: Secretary of State's powers to transfer or delegate functions

Part 3 of the Bill introduces a new power enabling the Secretary of State to transfer or delegate functions between specified arm's length bodies and abolish them where they become redundant as a result of any such transfers. We welcome the clarification provided in the Bill that those arm's length bodies with enduring regulatory roles and whose independence is essential to them performing these roles, eg, the Care Quality Commission and the National Institute for Health and Care Excellence, are now excluded from this power. We also welcome the specification in the Bill that while the Secretary of State is able to transfer functions from NHS England, they are unable to do this if it would render NHS England redundant as a result, providing NHS England with some protection.

Cross-cutting issues

Timing of the legislation

These proposals come at a time when the NHS, local authorities and voluntary and community sector organisations are still dealing with Covid-19 and its impacts. The move to ICSs will mean a lot of change for commissioning bodies and their staff, with clinical commissioning groups coming to an end and their functions being folded into new bodies. Given that previous attempts at reorganisations have tended to overstate the benefits and understate the cost and disruption of change, a careful approach to implementation will be needed in order to avoid these recurring pitfalls.

It is, however, worth noting that many of these reforms build on existing work in many areas, and much of the legislation was requested by health and care leaders themselves. This Bill is not the starting pistol for a wholesale shift in focus, instead it aims to refine the legislative framework to better support the ongoing drive towards more joined-up care.

The limitations of what legislation can achieve

It is important to recognise the limitations of what legislative change can achieve. The Bill represents a welcome shift in emphasis towards more integrated working, but this will be critically dependent on new collaborative ways of working between organisations, leaders and teams across health and care. While legislation can remove some barriers to collaboration and co-ordination of local services, it will not deliver the changes in behaviour that are needed to fully harness the benefits of the integration agenda. Instead, behaviours and relationships that support collaboration will need to be developed, nurtured and modelled right across the health and care system, including within national bodies. Consideration should be given to how this cultural change will be supported, and how staff at all levels will be supported to genuinely collaborate across organisational and professional boundaries.

Nature of the legislation

Throughout the Bill, there is a tendency towards creating broad enabling powers for the Secretary of State, for example, over arm's length bodies. It is suggested that these are needed to enable the Secretary of State to respond more flexibly to rapidly changing circumstances, such as those seen during the pandemic. However, the legislation does not make clear why such powers would be needed outside a pandemic, nor why reducing parliamentary involvement in this way is merited.

These proposals will change the nature and extent of parliamentary scrutiny of the NHS, with a significant shift from primary to secondary legislation. In that sense, more power is being moved from previously independent arm's length bodies to the Secretary of State while at the same time, the Secretary of State will be subject to less parliamentary scrutiny of their actions. It will be important to debate these issues as the Bill progresses through parliament.

Health and care system reform in totality

While the Bill includes some limited, targeted changes to public health and social care, the proposals predominantly amount to reforms of the NHS – with a focus on integrating services, collaborating better with other partners, and the relative balance of power between national players.

The NHS does not work in isolation – public health, social care and the NHS are closely connected. There is clearly a risk that in setting out fixed plans for the NHS, the options for social care reform become limited.

While this Bill is not designed to reform adult social care, government does need to publish its often promised and long-overdue plans to reform the adult social care

system. Doing so would enable this legislation to be scrutinised and implemented in light of future changes to the structures and workings of care services that often work so closely with the NHS.

More broadly, there is a need for a clear overall vision for all three arms of the health and care system at national, regional and local levels. Such a vision would help position the NHS reforms within the wider picture and ensure that the NHS reforms do not inadvertently limit positive change in public health and social care.

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