The King's Fund

Ideas that change health care

Written submission

Health and Care Bill: Public Bill Committee submission from 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.

Summary

- 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.
- These reforms are complex and to help those who will implement them, the Committee should call on the government to set out a clear narrative as to how they will make a positive difference to patients and service users.
- We welcome that the legislation is designed to be permissive and flexible to local circumstance, avoiding the pitfalls of previous attempts at reorganisations that attempted to impose a one-size-fits-all solution. We recommend that the Committee resist specifying 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.
- To avoid the unhelpful politicisation of local service change decisions and avert the risk of a decision-making log jam, we urge the Committee to remove from the Bill those clauses that would give the Secretary of State greater powers to intervene in local service reconfigurations.
- The Committee should seek further clarification regarding the scope of the new powers of the Secretary of State to direct NHS England, including how they might be used and what scrutiny of their use will be put in place.
- We urge the Committee to support an amendment to mandate the publication of regular, independently verified projections of future demand and supply of the health and social care workforce in England.

- We recommend that the Committee should amend the Bill to make addressing health inequalities a core aspect of each element of the new 'triple aim' duty that will frame the priorities for NHS organisations.
- The Committee should consider whether adequate measures will be in place for Parliament and others to scrutinise use of the new powers conferred on the Secretary of State by this Bill.

Introduction

1. 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 in 2019. 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 the oversight of quality and safety.
2. This evidence submission focuses on Parts 1, 2, and 3 of the Bill, which deal with the NHS and its relationships to other parts of the system, including the Secretary of State, plus proposed changes to information sharing across the health and care system.

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

Integration and collaboration

3. 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.
4. 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. To support implementation, we believe there should be clarity on the purpose of these reforms. Alongside National Voices, Age UK, the Richmond Group of Charities and others we have produced a joint vision for what these reforms could achieve (National Voices *et al* 2021).

These reforms are complex and to help those who will implement them, the Committee should call on the government to set out a clear narrative as to how they will make a positive difference to patients and service users.

New structures (Part 1; Clauses 12-24)

5. 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 to develop a plan to address the broader health, public health, and social care needs of their local population.

6. Schedule 2 of the Bill states that 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 (Clause 20). We welcome this permissive approach as it gives areas the freedom to build on existing local relationships and partnerships.

Relationship between bodies (Clauses 19 and 20)

7. 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.
8. 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).
9. To illustrate the scope for confusion between plans, the Bill includes a general duty on the ICB to pay regard to the integrated care strategy produced by the ICP, but there is not a specific requirement for the ICB's 'forward plan' to enact the integrated care strategy. However, there is a specific requirement that the ICB forward plans take account of health and wellbeing board strategies, and the ICB must consult the health and wellbeing board in producing its plan. As the Bill passes through Parliament, consideration should be given to how the integrated care board in each system will be held to account for delivering against the integrated care strategy developed by the integrated care partnership.
10. This complexity may give rise to concern. However, while it does provide a challenge to local and national leaders, it must be remembered that the delivery of care is itself complex with services varying from the very local to the fully national. Equally, the needs of populations vary greatly, and it is important to give freedoms to local areas to respond to them. In summary, the temptation to impose a very simple structure on health and care carries the risk of imposing a one-size-fits-all architecture that removes the flexibilities needed to meet local needs.
11. 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, the clarity of vision/leadership locally and the support and time given to local areas to develop stronger system working. This further emphasises the importance of implementation.

The importance of partnership at the 'place' level

12. 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.
13. 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 (Clause 60).
14. We are pleased that the legislation avoids a one-size-fits-all approach to the local arrangements. 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).

We welcome that the legislation is designed to be permissive and flexible to local circumstance, avoiding the pitfalls of previous attempts at reorganisations. We recommend that the Committee resist specifying 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.

Removing competition

15. 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 (see for example, Dixon *et al* 2014). As we have seen throughout the Covid-19 pandemic, collaboration between organisations is key to driving innovation and improvement.
16. One of the changes is the reduction in compulsory competitive procurement (Clause 68). 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.
17. Some have raised concerns that this legislation will allow contracts to be awarded to new providers without sufficient scrutiny, opening the door to private providers. In fact, this is less likely under the new system with the NHS provider selection regime, (NHS England and NHS Improvement 2021) which allows for contracts to be rolled over where the existing provider is doing a good job, coupled with the duty on commissioners to act in the best interests of patients, taxpayers and their local populations.
18. Rather than 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. While it is important that the provider selection regime does not prove to be

more onerous than competitive tendering it is to replace, there may be a case for giving the ICP some oversight role over its functioning.

Secretary of State powers to intervene in local service reconfigurations

19. As it stands, the Bill (Clause 38; Schedule 6) 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.
20. 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. This could lead to any service change in the NHS – no matter how large or small – 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, which could dramatically reduce the ability of the NHS to manage its services day to day. For reforms that are intended to reduce bureaucracy, this could create one of the biggest bureaucratic burdens in recent memory.
21. We believe these new powers for the Secretary of State to intervene in local service changes should be stripped from the Bill.

To avoid the unhelpful politicisation of local service change decisions and avert the risk of a decision-making log jam, we urge the Committee to remove from the Bill those clauses that would give the Secretary of State greater powers to intervene in local service reconfigurations.

Secretary of State powers to direct NHS England

22. 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 (Clause 26, Clause 29).
23. In recognition of the increased range of functions this newly merged body will have, Clause 37 of the Bill includes measures to give the Secretary of State greater power to direct NHS England beyond the objectives set out in the government's NHS Mandate.
24. Since the 2012 reforms, many arm's length body powers have been consolidated into NHS England, and it is well recognised that the existing Mandate does not provide a good accountability vehicle for NHS England. This change provides a rationale for making changes to the Mandate to increase its flexibility.
25. 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; what they add to the reformed Mandate and existing framework agreement between the Department and

NHS England (2014); and the oversight and scrutiny in place to review how they are used.

The Committee should seek further clarification regarding the scope of the new powers of the Secretary of State to direct NHS England, including how they might be used and what scrutiny of their use will be put in place.

Health and care workforce

26. Before the pandemic, staffing shortages in the NHS and social care were endemic, chronic excessive workloads were commonplace and levels of stress, absenteeism and turnover were worryingly high (NHS England and NHS Improvement 2020; Skills for Care 2020). Many staff will emerge from the past 18 months 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.
27. Clause 33 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. 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 2027 to produce such a report.
28. Alongside many other organisations, we have called for a clause to mandate the regular publication of independently verified projections of future demand and supply of the health and social 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 a requirement would incentivise action on workforce planning to ensure supply meets demand.
29. The clause proposed by The King's Fund, Health Foundation and Nuffield Trust is as follows:
    a. *Health Education England must publish annual, independently verified projections of the future supply of the health care workforce in England and how those projections compare to projected demand for health care workforce in England for a 15-year period consistent with the long-term projections of health care spending produced by the Office for Budget Responsibility (OBR). The Secretary of State for Health and Social Care must ensure that annual, independently verified projections of the future supply of the social care workforce in England are published, setting out how those projections compare to projected demand for social care workforce in England for a 15-year period, consistent with the long-term projections of adult social care spending produced by the OBR.*

30. 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.

We urge the Committee to support an amendment to mandate the publication of regular, independently verified projections of future demand and supply of the health and social care workforce in England.

Tackling health inequalities

31. The pandemic has exposed deep and widening health inequalities between different population groups and geographical areas. To address this, reducing inequalities should be given a much higher priority in NHS performance-management and improvement approaches so that it moves from being a 'nice to have' to a 'must do' (Robertson *et al* 2021).
32. Clause 4 of 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 tackling health inequalities is given sufficient priority across the system, this duty should be amended to incorporate reducing health inequalities within the triple aim. If the triple aim is to be the guiding light for these new NHS organisations, it would be a missed opportunity not to do this.

We recommend that the Committee should amend the Bill to make addressing health inequalities a core aspect of each element of the new 'triple aim' duty that will frame the priorities for NHS organisations.

Part 2: Health and adult social care: information

Information sharing across services

33. The health and care system has long struggled to ensure that a patient's information follows their care pathway and is available to those professionals who need it to support the patient's health. The Bill (Clause 79) would mandate information standards as a mechanism to address the longstanding interoperability issues that can make it impossible to share data between some health and care IT systems.
34. The Bill also seeks to improve information sharing by empowering health and care provider organisations to request information from each other and creates a duty to share data which can be enforced by the use of fines. This is in addition to simplification of information governance arrangements, which should make the expectations on data sharing clearer to staff.
35. These changes could bring a step change in team-based continuity of care across provider organisations by enabling information to follow a patient, removing the need for them to repeat information or duplicate tests. This has the potential to substantially improve quality and experience of care services, and if provided with correct training, could also reduce staff workload as there will be less need to revisit past recorded information.

36. However, the necessary information standards, as with all digital and data, will need to evolve to continue to meet the needs of patients, service users, and the health and care system. It is therefore important that the new information standards are regularly reviewed and a roadmap exists for improving system functionality and safety.

Adult social care data

37. Clause 83 of the Bill would see powers that require providers of adult social care services to provide information about their services. This would bring social care data requirements more in line with NHS data requirements. This welcome change is a recognition that adult social care is part of the health and care infrastructure in England and has strategic, national value. However, the government should consider the resource impact of requiring additional data collection and reporting from already stretched social care providers.

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

38. Part 3 of the Bill (Clauses 86–92) 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.
39. We welcome the clarification provided in the Bill that these powers will not apply to 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. 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

Nature of the legislation

40. 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.
41. 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.

The Committee should consider whether adequate measures will be in place for Parliament and others to scrutinise use of the new powers conferred on the Secretary of State by this Bill.

Health and care system reform in totality

42. 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.
43. 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.
44. 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.
45. 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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