Queen's Speech debate: A plan for the NHS and social care

House of Commons, 19 May 2021

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS trusts and foundation trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate. NHS Providers has all trusts in voluntary membership, collectively accounting for £92bn of annual expenditure and employing more than one million staff.

Introduction

These are unprecedented times for trust leaders as they continue to respond to the Covid pandemic and its impact on health inequalities, meet rising demand for services, support an exhausted workforce and tackle a care backlog across acute, community and mental health services.

The pandemic showed how capable the NHS is of making rapid changes in response to local and national needs. Trust leaders and their local partners freed up 30,000 beds to treat coronavirus patients this time last year, played a critical role in the vaccination roll out, worked together offering mutual aid on personal protective equipment, and flexed critical care, mental health and community teams, and ambulance capacity four months ago to avoid the system becoming overwhelmed shows that they can make rapid and radical changes.

As the country emerges from the pandemic, the NHS continues to face considerable challenges including in direct response to COVID-19. The significance of amending the legislative framework within which the NHS operates and the additional burden this will create for the NHS and its staff therefore should not be underestimated at this time. We support the Health and Social Care Select Committee's (HSCC's) call for the need for flexibility in the implementation timetable because of the post-pandemic backlog and the fact that different parts of England are at different points on the journey towards integration.

The Government has stated that the Health and Care Bill will allow it to build and shape a health system that is better able to serve the people of England in a fast-changing world. Its intention is to create a system that is more accountable and responsive to the people that work in it and the people that use it. We fully support those aims and warmly welcome the opportunity the Bill presents to design the right system architecture that will deliver sustainable high-quality care for the future.

We believe that there are a number of improvements that can be made which will make this the transformative piece of legislation the Government wants it to be.

Key recommendations for the Health and Care Bill

At this stage ahead of publication of the Bill, we have highlighted five key areas where we feel further debate would strengthen the current proposals. We will make further recommendations as the bill progresses through Parliament.

1. Integrated care systems (ICSs)

The Health and Care Bill presents an important opportunity to speed up collaboration between different parts of the NHS and social care within local systems, replacing competition with collaboration as the means to drive improvement for patients and service users. Trust leaders support this approach as the most effective way to tackle the significant challenges ahead on behalf of the populations they serve.

We welcome the ambition to create a flexible, enabling legislative framework that aims to avoid a 'one size fits all' model when placing integrated care systems (ICSs) on a statutory footing. This is important as ICSs cover a range of population sizes with different health needs, geographic characteristics and varying degrees of complexity within their local health economy. For several years now they have had the freedom to develop better joined up care and improve health outcomes in ways that work best for their communities and services. Proposed legislation must ensure that they can continue to build on this progress.

There needs to be flexibility in the implementation timetable to reflect the differences within ICSs, and that parts of the country will be at different starting points on this journey. NHS leaders should also have a role in setting the pace of the implementation to ensure that the establishment of ICSs will not adversely impact an area's COVID-19 response or recovery.

Therefore, we are supportive of the recommendation from the HSCC around the need, in the implementation period, to take "into account fully, the fact that parts of the country will be at different starting points on this journey" as well as recognising that "local NHS leaders have a role in setting the pace of the implementation to ensure that the establishment of ICSs will not adversely impact an area's covid-19 response or recovery".[1]

We welcome confirmation in the government *Integration and innovation* white paper, which set out proposals for the Health and Care Bill, that the statutory basis of trusts and foundation trusts will remain 'broadly unchanged', as the key unit of delivery for acute, mental health, ambulance and community services. Trusts' role as the leaders and co-leaders of system working, will continue to evolve in this new context. There is broad consensus that collaboration, and not competition, in local systems is already a positive driver of change to improve population health, tackle health inequalities and deliver sustainable care for the future.

However, there is a risk of unintended consequences within the legislation and in the design and practical implementation of accompanying guidance. There must be absolute clarity in the legislation on how the new and existing parts of the health and care system fit together. For these changes to work effectively we believe that there must be absolute clarity on how the accountabilities of all the parts of a local health and care system align without duplication, overlap or additional bureaucracy. This is vital given the level of risk, resource and complexity managed by trusts and their responsibility for providing high quality care to the public.

We recommend that the functions, duties and powers of the ICS NHS Body and of the ICS Health and Care Partnership (the two proposed component parts of an ICS), including mechanisms for agreeing membership, are set out in the Bill.

For those reasons, we support the HSCC recommendation that, "the Government include in the Bill a more detailed framework that sets out the roles and responsibilities of both the NHS Body and the Health and Care Partnership and of the Chair of the ICS. NHS England should set out in guidance how the responsibilities and accountabilities of NHS trusts and foundation trusts align with these to avoid confusion, duplication or overlap".[2]

[1] HSCC: The Government's White Paper proposals for the reform of Health and Social Care. Paragraphs 30 & 31

[2] HSCC: The Government's White Paper proposals for the reform of Health and Social Care. Paragraph 46

We share the concerns expressed by the HSCC that the absence of a fully funded plan for social care has the potential to destabilise ICSs and undermine their success. Therefore, we support this HSCC recommendation that, "The social care sector needs reassurance that both the structural and financial problems it faces will be tackled by the Government in a timely way. For that reason, we recommend that a duty is included in the Bill for the Secretary of State to publish a 10-year plan with detailed costings within six months of the Bill receiving Royal Assent".[3]

2. Powers of direction

We are concerned that the Government's planned powers of direction for the secretary of state could be too far-reaching, both individually and cumulatively. The White Paper proposals seem to reverse the decision in the Health and Social Care Act 2012[4] to introduce a helpful separation between political leadership and oversight and the clinical and operational day-to-day running of the service. Alongside other proposals for the secretary of state to have powers to create new trusts and intervene at any stage in NHS service reconfigurations, the proposed powers of direction over NHS England seem to suggest a swing of power towards the centre at the cost of the clinical and operational independence of the service, and of local accountability mechanisms. The HSCC echoes our concerns, stating that, "the White Paper does not give adequate detail on how the new powers proposed for the Secretary of State will be used. Nor does it set out the necessary safeguards to ensure that the powers do not open the door to the politicisation of the NHS".[5]

Parliament and the government may wish to reflect on whether these proposals expose the secretary of state, the service and patient care to undue, unmanaged risk. The proposed powers also need further investigation as they have the potential to cut across the secretary of state's duty to have regard to the NHS Constitution as set out in the National Health Service Act 2006: "The system of responsibility and accountability for taking decisions in the NHS should be transparent and clear to the public, patients and staff. The government will ensure that there is always a clear and up-to-date statement of NHS accountability for this purpose".[6]

We believe that these new powers must be framed in a way that maintains the NHS' clinical and operational independence and include an explicit public interest test, and support these proposals

[3] HSCC: The Government's White Paper proposals for the reform of Health and Social Care. Paragraph 65

[4] Health and Social Care Act 2012

[5] HSCC: The Government's White Paper proposals for the reform of Health and Social Care. Paragraph 96

[6] The NHS Constitution for England

from the HSCC: "We recommend that the Bill includes provisions that set out in detail, both the range and restrictions that will apply to each of the additional powers proposed including provisions for transparency around ministerial interventions and the operation of the public interest test."[7]

We believe this can be achieved by adding a number of safeguards to the Bill, and we would also recommend for the sake of transparency, the full reasoning behind each use of the power is published in parliament.

a) New powers over local reconfigurations

These proposals appear to give wide ranging powers to the secretary of state to direct local service reconfigurations, with few (if any) safeguards. Requirements for NHS bodies to notify the secretary of state of any planned reconfiguration risk creating a significant burden and require more thought.

Decisions on local service reconfiguration are best taken locally by the organisations that are accountable for those services following meaningful engagement with local communities. While clarity and speed can be welcome in making such decisions, this should not be at the expense of local engagement and decision-making. These powers appear to risk undermining local accountability in the NHS, and with regard to local authority overview and scrutiny committees; they do not necessarily protect the best interests of patients and run the risk of political interference in the provision of local NHS services. We therefore need to ensure that this power does not adversely affect services and patient care. This can be achieved by underpinning these powers with the following principles which should be explicitly set out in the Bill:

- any secretary of state involvement should be fully transparent, with the right of the affected parties to make appropriate representation and the secretary of state's intervention made against set, public, criteria such as an objective public interest test;
- there is an appropriate role for an independent body like the Independent Reconfiguration Panel to provide independent advice on detailed issues including the validity and importance of the clinical case for change;
- there should be an appropriate threshold governing the level of reconfiguration where the secretary of state is involved; and

[7] HSCC: The Government's White Paper proposals for the reform of Health and Social Care. Paragraph 97

- there should be an explicit test that use of the power must maintain or improve safety before it can be exercised.

Furthermore, we support the principles laid out in this recommendation from the HSCC: "We recommend that provisions be included in the Bill that set out the criteria under which the Secretary of State may intervene in reconfigurations. We further recommend that a duty be placed on the Secretary of State to lay before Parliament all information and advice in relation to an intervention in a reconfiguration".[8]

b) Powers over the newly merged NHS England

The White Paper was not clear on the new vision and scale of change inherent in these proposals for powers over NHS England, on why these new powers are required, and how and when they might be used. While we welcome reassurances in the White Paper that these powers would be rarely deployed, there needs to be further discussion about whether such broad powers are necessary and proportionate as well as specific criteria and a 'public interest test' for their deployment.

We therefore support these HSCC recommendations on how these powers should be set out in the bill: "We recommend that the Bill sets out in detail, the scope and areas of decision-making that will apply to this power. We further recommend that the Bill places a duty on the Secretary of State to publish any direction made by his office, including responses by the affected body, and that such powers are implemented in accordance with a public interest test".[9]

The Government must appropriately define the power in terms of:

- its scope and the areas of decision-making/activity where it might apply and, conversely, not apply;
- the need for full transparency when the power is exercised (including appropriate consultation with affected parties before the power is exercised and publishing their views); and
- a clear and transparent public interest test.

[8] HSCC: The Government's White Paper proposals for the reform of Health and Social Care. Paragraph 111

[9] HSCC: The Government's White Paper proposals for the reform of Health and Social Care. Paragraph Paragraph 102

c) New power to abolish and transfer powers to new arm's length bodies

The new power to move responsibilities between arm's length bodies via secondary legislation must not threaten the operational independence of key parts of the NHS. To protect that independence, we recommend that bill clearly sets out:

- the areas of decision making / activity where the powers will apply;
- when the power can be exercised, including a list of bodies outside the scope of the power;
- how appropriate consultation with affected parties will be conducted before the power is exercised; and
- a requirement to publish the views of the body being directed.

We support this HSCC recommendation that would give Parliament the ability to approve or reject such changes: "We recommend that the Bill includes schedules setting out the use and restrictions of the power to transfer responsibilities of Arm's Length Bodies – including a list of bodies outside the scope of the power. We further recommend that the affirmative procedure for secondary legislation is used in the transfer of functions and responsibilities of Arm's Length Bodies to ensure that Parliament has the ability to approve or reject such changes".[10]

The power to abolish the newly merged NHS England or the Care Quality Commission, or the power to transfer the majority of their powers to other bodies, requires proper parliamentary scrutiny. We therefore recommend that the bill sets out that such moves will require primary legislation.

d) New powers to create new trusts

Under the white paper proposals, an ICS will be able to apply to the secretary of state to create a trust. Further clarity is needed around the intended use of this proposal: at present new NHS foundation trusts cannot be established from scratch and the 2012 Act did not envisage the creation of new NHS trusts.

Given the complexity, financial and human resource, and the time taken to set up a new organisation at this scale and with this level of responsibility, we need to understand how this would be funded and implemented, how local consultation publicly and with the sector would operate, how the implications for existing trusts would be managed, and how the stability of the local health and care economy would be protected.

[10] HSCC: The Government's White Paper proposals for the reform of Health and Social Care. Paragraph Paragraph 117

We recommend that the bill sets out:

- the criteria that must be met for the establishment of a new trust including the demonstrable benefit for patients and the public;
- a requirement to consult the ICS and affected providers; and
- a requirement to publish those submissions.

3. Power over NHS foundation trusts' capital spending limits

This proposal arises from the need for the Department of Health and Social Care (DHSC) and NHS England to ensure that the national capital expenditure limit cannot be breached. It does this by offering a new power for NHS England to restrict the spending of any individual NHS foundation trust (FT) in the same way that expenditure by an NHS trust can already be limited. The power is not intended to be a general power used to set capital expenditure limits for all FTs, nor direct an FT in relation to individual capital investment decisions.

It is worth being mindful that this proposal does not address the root cause of the problem at hand which is prolonged underinvestment in the NHS estate and technologies, and the need for a national capital expenditure limit that fairly reflects the NHS' investment needs. Despite recent welcome injections of funding, the capital maintenance backlog now stands at £9bn. Over half of this is considered a 'high' or 'significant' risk to patients and staff. NHS Providers is therefore continuing to call for recent increases to the NHS' capital budget to be sustained in future years and be distributed fairly across the provider sector. Ultimately, a limit on FTs' capital expenditure is not going to improve patient safety, operational performance, efficiency nor the services' ability to transform and modernise care.

While we recognise the need, in the move to system working and given the overall national constraints on capital spending, for NHS England to introduce a reserve, backstop, power to set individual and time-limited FT capital spending limits, it is vital that use of this power is carefully controlled. It is absolutely right that FTs and trusts retain their current accountability for the delivery of safe care and having sufficient freedom over capital expenditure is central to this task.

The proposed power on NHS FTs' capital spending limits must reflect the precise wording of the 2019 proposals developed by NHSE/I which were agreed with NHS Providers. We therefore seek to ensure that this power is framed as a narrow reserve power on the face of the bill.

These safeguards would require NHS England to:

- only apply the power to a single, named FT;
- automatically cease the power at the end of the current financial year;
- explain why the use of the power in each case is necessary;
- provide details of what steps it had taken to avoid requiring its use;
- include representations received from the FT affected; and
- be fully transparent by publishing its reasoning, ideally in Parliament.

4. Workforce

The NHS needs a regularly produced, long-term, workforce numbers plan setting out the desired future shape and size of the NHS workforce. While we welcome the new duty on the secretary of state to set out how workforce planning responsibilities are to be discharged, we believe this duty needs to be considerably strengthened.

We welcome the support of the HSCC for our view that the government duty – as currently set out in the White Paper – to publish an update on workforce roles and responsibilities once every five years is an inadequate response to shortages that are endemic in the NHS and we support their recommendation that, "That the Government include in the Bill, provisions to require Health Education England to publish objective, transparent and independent annual reports on workforce shortages and future staffing requirements that cover the next five, ten and twenty years including an assessment of whether sufficient numbers are being trained. We further recommend that such workforce projections cover social care as well as the NHS given the close links between the two systems. These reports should include input from staff, NHS bodies and unions, and content on the sufficiency of training should be reviewed by independent experts prior to publication".[11]

In addition, we recommend inclusion in the Bill a duty on the secretary of state to regularly update Parliament, more than once a Parliament, on the government's strategy to deliver those long-term projections, including its approach to providing the required funding.

[11] HSCC: The Government's White Paper proposals for the reform of Health and Social Care. Paragraph 87

5. The Health Service Safety Investigations Body (HSSIB)

The body that will be constituted as the Health Service Safety Investigations Body (HSSIB) conducts independent investigations of patient safety concerns in NHS-funded care across England. Central to its work is a commitment in their investigations to providing a 'safe space' for participants, including patients, families and staff, to share information.

We have a number of concerns about how the proposals in the White Paper will lessen HSSIB's independence and therefore its ability to carry out its intended role. In particular, we note its functional independence is in question, as it is set to be established as an executive non-departmental body rather than directly accountable to parliament.

We also note two proposed powers: (1) the ability of the secretary of state to require HSSIB to investigate particular qualifying incidents; and (2) the power of the secretary of state to set out when safe space provisions do not apply.

Greater clarity of intent is required here. Any use of the power to require an investigation needs to be done cautiously and sparingly. To do otherwise risks destabilising HSSIB and undermining its independence, as well as potentially detracting from the multiple official procedures that are carried out by providers and external bodies following an incident. We believe as part of any such power, HSSIB should have the right to refuse a request where there is reasonable justification, or to ensure it is appropriately resourced to take up a request. The guaranteed independence of its recommendations arising from any such investigations is paramount.

Regarding the power to set out when 'safe space' provisions do not apply, we are concerned to see the drafting here and the limits it places on this power. If the requirements of 'safe space' are not properly respected, the exercise of this power could significantly compromise trust in HSSIB's investigations and undermine the original intent of the organisation which was to focus on learning not blaming. More broadly, a wider framework – for example, returning investigations to the NHS after a period of time – also needs to be considered.

In addition, many of the provisions made in the earlier Health Service Safety Investigations Bill are not mentioned in the White Paper. Our concerns relating to that Bill included the provisions for disclosure of 'safe space' materials and related powers of compulsion to disclose information, especially regarding coroners. We await further detail in the Health and Care Bill to see if our concerns have been addressed.

NHS Providers' pre-legislative work

Briefings further to the DHSC White Paper, *Integration and Innovation: working together to improve health and social care for all*, which set out the proposals for the Health and Care Bill:

- On the day briefing, Legislating for Integrated Care Systems, 11 Feb 2021
- Written evidence to the Health and Social Care Committee inquiry, 25 February 2021
- Oral evidence to the Health and Social Care Committee inquiry, 2 March 2021
- Supplementary evidence to the Health and Social Care Committee, 26 March 2021
- On the day briefing, Queen's Speech, 11 May 2021

Parliamentary briefings:

- Health Services Safety Investigations Bill, October 2019
- House of Lords Queen's Speech debate, 12 May 2021