The Health and Care Bill

House of Commons, Bill Committee, 21 September 2021 – consideration of clauses 26-78

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.

The majority of the Health and Care Bill (the Bill) is focused on developing system working, with integrated care systems being put on a statutory footing. It also formally merges NHS England and NHS Improvement. A comprehensive summary of key parts of the Bill as well as NHS Providers' views on those provisions can be found here.

We support the opportunity the Bill presents to design the right system architecture that will deliver sustainable high-quality care for the future. However, we also believe there are improvements that can be made which will make this the transformative piece of legislation the government wants it to be.

Amendments covered in this briefing

Clauses 26-32 (Merger of NHS bodies etc) and Schedule 5 (Abolition of Monitor and transfer of its functions)

- NHS Providers view on clause 27

Clauses 33-38 (Secretary of state's functions) and Schedule 6 (Intervention powers over the reconfiguration of NHS services)

- Amendment 94
- Amendment 108
- NHS Providers view on clause 37

- Amendment 35

Clauses 74-78 (Miscellaneous)

- Amendment 98

Clauses 26-32 (Merger of NHS bodies etc) and Schedule 5 (Abolition of Monitor and transfer of its functions)

Clause 26 abolishes Monitor, with Schedule 5 making consequential amendments relating to the transfer of Monitor's functions to NHS England. This fulfils the intention of the Department of Health and Social Care (DHSC) to merge Monitor into NHS England to form a single body. Clause 27 places a duty on NHS England to minimise the risk of conflict between its regulatory and other functions and to manage any conflicts that arise. Clause 28 adds to current provisions to require an impact assessment before modification of standard licence conditions in all providers' licences or in licences of a particular description. Clause 29 transfers powers from the Trust Development Authority (TDA) to NHS England and abolishes the TDA.

Overall, we support the move to merge Monitor and the TDA, currently known as NHS Improvement, into NHS England and welcome the consistency and clarity it will offer. However, we note this raises a series of questions for NHS England in the future as it will concurrently set the national policy framework, support sector and organisational improvement, and acts as a regulator. The merger removes the inherent tension deliberately created by the Health and Social Care Act 2012 which replicated a commissioner/provider split at a national level and consolidates the direction of travel with NHS England operating as an integrated body. While the Bill contains some useful provision for the newly merged NHS England to manage conflicts of interest, this does not negate the fact that it will be required to oversee and regulate the outcome of its own decisions.

NHS Providers' analysis

Clause 27

Clause 27 places a duty on NHS England to minimise the risk of conflict between its regulatory and other functions and managing any conflicts that arise.

NHS Providers' view

The formal merger of NHS England and NHS Improvement, with the abolition of Monitor and the TDA, creates a risk of conflicts of interest between the regulatory function of Monitor and NHS Improvement and the transformation and commissioning functions of NHS England. Clause 27 requires NHS England to minimise conflicts of interest in the exercise of its new regulatory functions and to manage those conflicts that may arise. However, this does not necessarily remove the eventuality that NHS England would be required to oversee and regulate the outcome of decisions it has made. Therefore, the wording which requires NHS England to 'minimise' and 'manage' conflicts of interest does not remove the inherent clash of responsibilities and we would recommend adding stronger safeguards on the face of the Bill which would require NHS England to 'avoid' conflicts of interest.

Clauses 33-38 (Secretary of state's functions) and Schedule 6 (Intervention powers over the reconfiguration of NHS services)

These clauses set out powers of direction for the secretary of state in relation to public health, NHS England, safety investigations, reconfiguration of services and a duty to publish an assessment of the workforce needs of the health service in England.

Clause 33 places a duty on the secretary of state to publish, at least once every five years, a report describing the system in place for assessing and meeting the workforce needs of the health service in England. It will also place a duty on Health Education England (HEE) and NHS England to assist in the preparation of the report, if asked to do so by the secretary of state. The intent of this clause is to add clarity and transparency on roles and responsibilities within the NHS on workforce planning. This is a welcome step forward and acknowledgement of the multiple bodies involved in this work.

Clause 36 relates to the investigation functions currently held by the TDA in relation to the Healthcare Safety Investigation Branch (HSIB) and transfers these to NHS England.

Clause 37 gives the secretary of state the power to direct NHS England in relation to its functions. There are exceptions to this power – the secretary of state cannot use the power in relation to the appointment of individuals by NHS England (including trusts and foundation trusts), individual clinical decisions, or in relation to drugs or treatments that the National Institute for Health and Care Excellence (NICE) have not recommended or issued guidance on as to clinical and cost effectiveness.

Clause 38 gives wide ranging powers to the secretary of state to direct local service reconfigurations.

Amendment 94 (Clause 33)

Member's explanatory statement

This amendment would require assessments to be published every two years of the current and future workforce numbers required to deliver care to the population in England, based on the economic projections made by the Office for Budget Responsibility (OBR), projected demographic changes, the prevalence of different health conditions, and the likely impact of technology.

NHS Providers' view

The duty as currently drafted will simply maintain the status quo. This amendment will give us the best foundation to take long-term decisions about workforce planning, regional shortages and the skill mix to help the system keep up with service user need. Transparency on projections enables the system to plan and policy makers to scrutinise. It is a way to ensure that the NHS has the staff numbers required to deliver the work that the OBR estimates the service will need to carry out in future.

We do not think that a workforce planning document as set out in the Bill will be sufficiently responsive to potential societal shifts and support the two-year reporting cycle put forward in this amendment. We believe that this would allow government and other bodies sufficient time to begin taking action in response to the projected numbers, without allowing too long between reporting cycles. The amendment also would ensure close engagement with trusts and other key stakeholders in the creation of the assessments, and for the assessment report to be presented to parliament; we support this as it encourages greater transparency and accountability in regard to workforce planning. This amendment has broad support from a number of stakeholders including NHS Providers, the Royal College of Physicians and Macmillan Cancer Support.

Amendment 108 (Clause 36)

Member's explanatory statement

This amendment will ensure nothing in new section 7D of the NHS Act 2006 about the secretary of state's powers to direct the Health Service Safety Investigations Body (HSSIB) supersedes what is in Part 4 of the Bill.

NHS Providers' view

Further clarity on clause 36 and how it works alongside Part 4 of the Bill and the work of the HSSIB would be welcome. One of the purposes of clause 36 is to transfer the role held by the TDA

regarding the HSIB to NHS England. However, as the HSSIB will be an independent body established by this Bill, we would welcome clarity regarding whether this is a technical change as a result of the dissolution of the TDA, or whether NHS England have a continuing role. If the intention is for NHS England to continue playing a role, we would welcome more information about its extent, as well as clarification as to whether the secretary of state has any ability here to set up an alternative investigations body.

It is key that this clause does not compromise the independence on the HSSIB – and that further amendments are made to Part 4 of the Bill to assure the HSSIB's independence (for example, relating to how the HSSIB may respond to any direction from the secretary of state to carry out an investigation).

It would also be helpful to understand the intended approach to the maternity investigations currently undertaken by the HSIB. The HSIB has had a valuable role in identifying how NHS providers can sustainably and systematically improve the quality of their maternity investigations and then appropriately support those providers to make the required improvements. However, it remains important for these investigations return to the NHS at an appropriate point to ensure proper accountability, to support a trust's relationships with the affected families and staff, and to avoid the loss of skill within the NHS in carrying out such investigations.

Clause 37

Clause 37 gives the secretary of state the power to direct NHS England in relation to its functions. There are exceptions to this power – the secretary of state cannot use the power in relation to the appointment of individuals by NHS England (including trusts and foundation trusts), individual clinical decisions, or in relation to drugs or treatments that the NICE have not recommended or issued guidance on as to clinical and cost effectiveness.

NHS Providers' view

As currently drafted, clause 37 appears to signal a recentralisation of power and to open up the possibility of ministers' involvement in aspects of the operational management of the health service. This could also leave the secretary of state able to intervene in individual funding allocations.

We are concerned that without appropriate safeguards in place, decisions might be reached based on political motivation rather than focused on the best interests of services and populations. The clinical and operational independence of the NHS must be maintained to ensure equity for patients

within the service, best use of constrained funding, and clinical leadership with regard to prioritisation and patient care.

The lack of safeguards here could arguably expose the government, any secretary of state, the service, and patient care to undue, unmanaged risk. The clause indicates that a direction must include a statement that the secretary of state considers the direction to be in the public interest and that this should be published as soon as is reasonably practicable. We believe there needs to be further discussion about whether such broad powers are necessary and proportionate and would also encourage setting out specific criteria that must be met and a 'public interest test' for the deployment of these powers. We believe that any direction given by the secretary of state should be in the public good, its impact should be understood, and such impacts should be reviewed so that adverse effects can be rectified.

Amendment 35 (Clause 38)

Member's explanatory statement

This amendment would remove clause 38, which introduces Schedule 6, which confers intervention powers on the secretary of state in relation to the reconfiguration of NHS services, from the Bill.

NHS Providers' view

Clause 38 gives the secretary of state intervention powers in relation to the reconfiguration of NHS services. As currently drafted, clause 38 gives wide ranging powers to the secretary of state to direct local service reconfigurations, and does so without appropriate safeguards.

Decisions on local service reconfigurations 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.

The proposed powers risk undermining local accountability in the NHS, and 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. In order to ensure that this power does not adversely affect services and patient care, we believe that the following principles should be applied and set out on the face the Bill:

1. 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;
2. 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;
3. There should be an appropriate threshold governing the level of reconfiguration where the secretary of state is involved; and
4. There should be an explicit test that use of the power must maintain or improve safety before it can be exercised.

Clauses 74-78 (Miscellaneous)

Clauses 74-78 cover a number of miscellaneous issues including requirements for Special Health Authorities in relation to their accounts and auditing; repealing the powers of the secretary of state in the 2012 Act to make a property transfer scheme or a staff transfer scheme in connection with the establishment or abolition of a body by the 2012 Act, or the modification of the functions of a body or other person by or under that Act; the abolition of Local Education and Training Boards; and revoking section 74 of the Care Act 2014 and schedule 3 of the Care Act 2014.

Amendment 98 (Clause 78)

Amendment 98 relates to clause 78 (Hospital Patients with care and support needs: repeals etc). It calls for changes to the discharge to assess policy.

NHS Providers' view

While we support the intentions behind this amendment, which seek to ensure the timely assessment of patients, we believe that some of the proposed changes go against the existing direction of travel for the discharge to assess policy. For instance, the requirement that 'a social care needs assessment must be carried out…before a patient is discharged from hospital or within two weeks of the date of discharge', set out in this amendment, creates an arbitrary threshold, and runs contrary to the existing NHS England and NHS Improvement discharge guidance, which states that 'social care needs assessments and NHS Continuing Healthcare assessments should be made in a community setting'. We would suggest that recommendations around the appropriate timeframe for an initial needs assessment should be placed in guidance rather than legislation. Furthermore, the reference to

penalties for not meeting the required timeframe would in effect return us to the previous system of penalties while failing to address the issues that cause delays.

We support efforts to better understand the effectiveness of this policy, particularly as the handover between the NHS and social care has historically been difficult in some areas. Further detail is needed about the nature of the data collection recommended in the amendment (including the potential burden for NHS and social care providers), and the intended purpose of this publication. Committee members may wish to query how this report would increase effectiveness, without addressing significant issues around social care workforce shortages and lack of certainty around discharge to assess funding beyond the end of this financial year.