The Health and Care Bill

House of Lords, Committee of the whole House: Clauses 35 - 67 and Schedule 6

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 (ICSs) being put on a statutory footing. It also formally merges NHS England and NHS Improvement (NHSE/I), and makes changes relating to public health, social care and patient safety.

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. NHS Providers has commented extensively on the Bill since its publication. Our briefings and written evidence to date can be found here and detailed background about Integrated Care Systems (ICSs) can be found here. This briefing examines a number of amendments to clauses 35-67 included in Part 1 of the Bill.

Key points

- This briefing focuses on amendments to clauses 35-67 and Schedule 6 of the Bill. It also includes analysis of some clauses we prepared to facilitate the committee's scrutiny of those provisions.

- We are concerned that provisions in the Bill open up the possibility of political interference in the health service by drawing significant powers of intervention and direction to the secretary of state. Maintaining the clinical and operational independence of the NHS is vital to ensuring this complex system can work effectively. Similarly, we are concerned that new powers to allow the secretary of state to intervene in local service reconfigurations, as currently drafted, risk undermining local accountability in the NHS.
- We welcome measures in the Bill to place a new duty on the secretary of state setting out how workforce planning responsibilities are to be discharged but believe this duty needs to be strengthened.
- The Bill gives a new power to NHS England to restrict the spending of any individual NHS foundation trust. We wish to see important safeguards added to this proposal within the Bill to mirror what was agreed in NHS England's 2019 legislative proposals.

Amendments and clauses covered in this briefing

Clauses 35-40 (Secretary of State's functions) and Schedule 6 (Intervention powers over the reconfiguration of NHS services)

- Amendment 170 (Clause 35: Report on assessing and meeting workforce needs)
- Clause 38 Power of direction: investigation functions
- Amendment 174A, 174B, 175A, 176A, (Clause 39: General power to direct NHS England)
- Amendments 179-183 (Schedule 6: Intervention powers over the reconfiguration of NHS services)

Clauses 53-59 (NHS Foundation trusts)

- Amendments 188-192 (Clause 54: Capital spending limits for NHS foundation trusts)

Clauses 64-67 (Collaborative working)

- Clause 64

Clauses 35-40 and Schedule 6

Amendment 170 (Clause 35: Report on assessing and meeting workforce needs)

Member's explanatory statement

This amendment would require the Government to publish independently verified assessments every two years of current and future workforce numbers required to deliver care to the population in England, taking account of the economic projections made by the Office for Budget Responsibility, projected demographic changes, the prevalence of different health conditions, and the likely impact of technology.

NHS Providers' view

While we welcome clause 35 which will place a 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 support the position set out by a broad coalition of organisations, which proposes an amendment to the Bill calling for the secretary of state to publish, every two years, independently verified assessments of current and future workforce numbers consistent with the Office for Budget Responsibility (OBR) long-term fiscal projections.

Ensuring we have the right levels of staff to care for patients now and in future is key – recent analysis from the Health Foundation shows that over a million more health and care staff will be needed in the next decade to meet growing demand for care. The gap between service demand and workforce supply is a significant concern which must be addressed if the NHS is to protect its staff from burnout alongside meeting rising demand pressures and recovering from the COVID-19 pandemic. Our 2021 State of the provider sector report found that almost all (94%) trust leaders were extremely or moderately concerned about the current level of burnout in their workforce. Pressing workforce shortages and the resulting unsustainable workload on existing staff can only be tackled with a robust long term workforce plan.

Amendment 170 will give the NHS 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.

Amendments 174A, 174B, 175A, 176A (Clause 39: General power to direct NHS England)

Amendments to Clause 39 in the name of Lord Hunt of Kings Heath, would reduce the scope of the Secretary of State powers to direct NHS England by adding safeguards and additional exceptions.

NHS Providers' view

Clause 39 of the Bill (General power to direct NHS England), as currently drafted, appears to open up the possibility of ministers' involvement in aspects of the operational management of the health service. We are concerned that without appropriate safeguards in place, decisions would be much more likely to be swayed by political motivations rather than being objectively evaluated on the basis of the interests of patient populations and quality of care.

Clinical and operational independence must be maintained in order to ensure equity for patients within the service; the best use of constrained funding; and clinical leadership with regard to prioritisation and patient care.

While the intention may be to deploy these powers on rare occasions, the potential impact is so great that safeguards must be put in place. We welcome the decision to add a duty to publish a direction but believe additional safeguards are needed to protect the NHS's independence by defining the power in terms of:

a. The publication of guidance defining an objective "public interest" test, its scope and the areas of decision making and activity where it might apply and, conversely, not apply. As drafted, the language is subjective and unclear. In line with the use of this test in other regulatory settings, there should be clear, proportionate and necessary criteria before the power is exercised.
b. The need for full and timely transparency when the power is exercised – we believe this should include the need for the secretary of state to set out why their use of the power of direction, on each occasion, meets an objectively defined public interest test before giving a direction.
c. The need for appropriate consultation with affected parties before the power is exercised including, as part of the transparency arrangements, the publication of the views of the body being directed.

A lack of safeguards could arguably expose the government, any secretary of state, the service, and patient care to undue, unmanaged risk. We believe there needs to be further discussion about whether such broad powers are necessary and proportionate. 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.

Please find here a joint briefing from NHS Providers, the NHS Confederation and the King's Fund setting out their support for these amendments which add these essential safeguards.

Amendments 179-183 (Schedule 6: Intervention powers over the reconfiguration of NHS services)

This group of amendments set out a number of safeguards concerning the reconfiguration of services. These amendments would ensure that there is an appropriate threshold governing the level of reconfiguration in which ministers could get involved. It would guarantee that any ministerial intervention must be fully transparent with provision for affected parties to make appropriate representations, and that a decision must be made promptly. It would also remove the power of the secretary of state to act as the catalyst for a reconfiguration. Given the overwhelming importance of patient safety in these considerations, the amendment adds an explicit test that use of the power must maintain or improve safety before it can be exercised.

NHS Providers' view

Schedule 6 sets out the secretary of state intervention powers in relation to the reconfiguration of NHS services as contained in clause 40. As currently drafted, the schedule details the wide-ranging powers to the secretary of state to direct local service reconfigurations and does so without appropriate safeguards leaving open the potential for the most senior political involvement in a range of decision making from relatively small reconfigurations (within and by a single provider for example) to larger schemes which require clinical leadership, objective evaluation of the options and full public consultation.

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. These proposals will not necessarily protect the best interests of patients and run the risk of political interference in the provision of local NHS services.

We welcome this amendment which would:

- Ensure that there is an appropriate threshold governing the level of reconfiguration where ministers get involved
- Guarantee that any ministerial intervention must be fully transparent with provision for affected parties to make appropriate representations, and a decision must be made promptly
- Remove the power of the secretary of state to act as the catalyst for a reconfiguration
- Add an explicit test that use of the power must maintain or improve safety before it can be exercised
- Require the secretary of state to consult all relevant Health Overview & Scrutiny Committees, those organisations delivering the services under consideration of reconfiguration, and the Integrated Care Board, and to publish those submissions.

Please find more detailed information on this group of amendments in this joint briefing from NHS Providers, the NHS Confederation and the King's Fund, who support amendments adding essential safeguards to these powers.

Clauses 53-59

Amendments 188-192 (Clause 54: Capital spending limits for NHS foundation trusts)

Member's explanatory statement

This amendment along with the other amendments in the name of Lord Crisp to Clause 54 seek to deliver the legislative proposals agreed with NHS England and NHS Improvement in 2019.

NHS Providers' view

Clause 54 gives a new power to NHS England to restrict the spending of any individual NHS foundation trust in the same way that capital 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 foundation trusts. This proposal arises from the need for the Department of Health and Social Care and NHS England to ensure that the national capital expenditure limit cannot be breached.

The rationale is that the lack of mechanisms to set capital spending for NHS foundation trusts is a barrier to a more collective approach, and that, because of uncertainty around foundation trust capital spending, there may be instances where it is necessary to constrain or delay capital spending by non-foundation trusts that may be more urgent or addresses higher priority needs than foundation trust plans. We recognise this issue and the importance of addressing it.

NHS Providers agreed the NHS capital regime needed to be reformed. We have called for a more robust, efficient, and timely capital bidding and prioritisation regime, with a clear set of rules and criteria. Such a system is vital to giving providers the certainty they need and to spend capital in the context of system working.

We must be 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. We welcomed the multi-year capital investment for the NHS announced at the October 2021 Spending Review. However, the capital maintenance backlog now stands at £9.2bn. Half of this is considered a 'high' or 'significant' risk to patients and staff. We are 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.

While we recognise the need, in the move to system working and given the overall national constraints on capital spending, for NHS England to have a reserve, backstop, power to set individual foundation trusts capital spending limits, it is vital that use of any such power on foundation trust capital investment is carefully controlled. It is absolutely right that foundation trusts 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 current drafting of clause 54 does not mirror NHSE/I's September 2019 legislative proposals which was the result of detailed negotiations with NHS Providers on behalf of our foundation trust members. This clause also cuts across the Health and Social Care Committee's unequivocal position that the power to set capital spending limits for foundation trusts "should be used only as a last resort".

Below are the safeguards that were agreed with NHSE/I as part of the September 2019 legislative proposals and which we consider essential to see in the Bill. Those proposals gave NHSE/I a reserve power subject to the following safeguards:

1. Each use of the power should apply to a single named foundation trust individually;
2. NHSE/I was required to explain why use of the power was necessary, describing what steps it had taken to avoid its use and include the response of the foundation trust when publishing each order;
3. Any foundation trust's capital spending limit set, using the power, should automatically cease at the end of the current financial year; and
4. The power to set capital spending limits for foundation trusts should be circumscribed on the face of the Bill as a narrow reserve power.

Clause 64 (Repeal of duties to promote autonomy)

Lord Lansley gives notice of his intention to oppose the Question that Clause 64 stand part of the Bill.

NHS Providers' view

We note that clause 64 explicitly removes duties on the secretary of state and on NHS England to 'promote autonomy'. This reflects provisions elsewhere in the Bill to alter the relationship between the secretary of state and NHS England. Although this is in line with the direction of travel for trusts and their partners as they embed more collaborative arrangements within local systems (and sits in contrast to the 2012 Act which actively promoted competition) there still needs to be clear lines of accountability within the system, including clear lines of accountability from trust boards for the quality of care they deliver, and as large employers. In our view organisational autonomy can exist alongside collaboration and co-operation and therefore we support this amendment.

This point is also made in the House of Lords Constitution Committee report on the Bill, where they conclude: "Clause 64 would remove section 5 of the Health and Social Care Act 2012, which requires the secretary of state to have regard to the desirability of maintaining the autonomy of health service functions. Coupled with new powers for the secretary of state of oversight, delegation and transfer of functions, this could alter the balance between the Government's constitutional responsibility for the provision of health care and providers' ability to function in a manner that can respond effectively to local needs. It also risks undermining accountability by making it more difficult to understand which body is responsible for a particular function of the NHS."