Health and Care Bill – House of Commons, Consideration of Lords amendments, March 2022

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 foundation trusts and 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 England in voluntary membership, collectively accounting for £104bn of annual expenditure and employing 1.2 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 made in the other House which will make this the transformative piece of legislation the government wants it to be. This briefing sets out our analysis of amendments and new clauses added in the other House which we want to see retained in the Bill. We also support a government amendment relating to the composition of Integrated Care Board (ICBs) sub-committees.

NHS Providers has commented extensively on the Bill since its publication. Our briefings and written evidence to date can be found here.

Issues covered in this briefing

- Establishment of integrated care boards
- Clause 41 – report on assessing and meeting workforce needs
- Clause 45 – General powers to direct NHS England
- Reconfiguration of services: intervention powers – removed by the other House
- Schedule 14 - Prohibition on disclosure of HSSIB material: exceptions & Clause 124 - Restriction of statutory powers requiring disclosure

Establishment of integrated care boards

Lords Amendment No. 11
Edward Argar: To move, That this House disagrees with the Lords in their Amendment.
To move the following Amendment to the Bill in lieu of the Lords Amendment:—

Page 138, line 35, at end insert—
"(4) If the constitution includes provision under this paragraph allowing committees or sub-committees to exercise commissioning functions, the constitution must— (a) provide for the members of any such committee or sub-committee to be approved or appointed by the chair of the integrated care board, and
(b) prohibit the chair from approving or appointing someone as a member of any such committee or sub-committee ("the candidate") if the chair considers that the appointment could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.
(5) In sub-paragraph (4) "commissioning functions" means the functions of an integrated care board in arranging for the provision of services as part of the health service."

NHS Providers' view

Each ICB is required to maintain and publish a register of interests of its board members, committee or sub-committee members, and its employees. The board must ensure that any potential conflicts of interest that may affect the board's decision-making when commissioning services are declared promptly and managed effectively. Schedule 2 sets out that the constitution must specify that an ICB must not appoint a person as member of an integrated care board if that appointment could reasonably be regarded as undermining the independence of the NHS because of their involvement in the private health sector or otherwise. We also understand that national support and guidance will be available for ICB chairs to advise on specific arrangements and clarify whether, in practice, an ICB member could also be a director / shareholder / employee of any private company. For example, many non-executive directors hold more than one position across different sectors.

The ICB is the accountable body when it comes to allocation of NHS resources, including via delegations to joint committees. These joint committees could refer to place-based partnerships, for example, which bring together a wide range of partners across the health and care system (including the voluntary and community sector, as well as some independent providers e.g. social care or private healthcare providers) to collectively decide how best to design and deliver services at place level to

meet local population needs. In line with the general commitment to flexibility and to local / system autonomy, we think there could be circumstances where a local private or voluntary sector provider would be well placed to join a joint committee with a focus on integrated service delivery whereby the usual arrangements to identify and manage conflicts of interest would, and should, apply.

NHS Providers welcomes this amendment. We have been working with government and opposition members to agree changes which would support providers' involvement in sub-committees while also ensuring systems can effectively manage any potential conflicts of interest. The previous Lords amendment, which ostensibly focused on preventing independent sector organisations sitting on ICBs and their sub-committees, risked the unintended consequence of preventing (or at minimum hampering) provider organisations, including trusts, from participating fully in place-based decision making. There are well established approaches in which board, and committee members declare interests such that they can be managed when they do arise. This amendment extends the same principle to ICB sub-committees and empowers chairs to make decisions about memberships of sub-committees based on local context and with knowledge of interests. This is consistent with the government's earlier amendments which prohibit the appointment of any member to an ICB if their involvement would undermine the independence of the NHS and with the ethos of chairs taking these decisions locally.

Clause 41 – Report on assessing and meeting workforce needs

NHS Providers' view

We strongly support this new clause which was added in the other House and is supported by a coalition of over a hundred organisations in the health and care sector. The clause creates a duty on 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.

Analysis published by NHS Providers this week shows that staff shortages across the NHS are having a "serious and detrimental impact" on services and will hinder efforts to tackle major care backlogs and improve access to services. An overwhelming majority of trust leaders (89 per cent) do not think the NHS has robust plans in place to tackle workforce shortages. Our survey also found that, in line with this amendment, trust leaders overwhelmingly (88 per cent) want the government to be required by law to publish regular, independent assessments of how many health and social care staff are needed to keep pace with projected demand over the next five, ten and 20 years. Pressing workforce shortages and the resulting unsustainable workload on existing staff can only be tackled with a robust long term workforce plan.

We do not think that the workforce planning document, set out originally in the Bill, will be sufficiently responsive to potential societal shifts. Instead we support the two-year reporting cycle put forward in this amendment. The amended provision 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 Office for Budgetary Responsibility (OBR) estimates the service will need to carry out in future. We believe that this would allow government and other bodies sufficient time to take action in response to the projected numbers, without allowing too long between reporting cycles. This provision would also 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.

Clause 45 – General powers to direct NHS England

NHS Providers' view

Clause 45 of the Bill (General power to direct NHS England), opens 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.

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.
d. 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.

A lack of safeguards could arguably expose the government, any secretary of state, the service, and patient care to undue, unmanaged risk. While the intention may be to deploy these powers on rare occasions, we have not seen any draft guidance setting out what criteria the secretary of state will use when deciding whether or not to use these powers. We urge the House to seek further clarification on when this guidance will be published.

Reconfiguration of services: intervention powers

NHS Providers' view

The other House removed the reconfiguration of services powers from the Bill. We supported its removal because the provisions gave wide-ranging powers to the secretary of state to direct local service reconfigurations and did 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 risked undermining local accountability in the NHS, and local authority overview and scrutiny committees. They also failed to protect the best interests of patients and run the risk of political interference in the provision of local NHS services. We will continue to support removal of these powers until appropriate safeguards are added.

Schedule 14 – Prohibition on disclosure of HSSIB material: exceptions & Clause 124 – Restriction of statutory powers requiring disclosure

NHS Providers' view

The other House removed the provision allowing coroners to require the disclosure of protected material which we support.

The impact assessment for HSSIB's provisions in the Health and Care Bill sets out that the intended effects of HSSIB are to:

- "[improve] public confidence in investigations arising from both the independence of HSSIB and the provision of 'safe space' to protect confidential information from disclosure;
- …make recommendations that improve patient safety across the system;
- encourage a culture of learning and safety improvement throughout the healthcare system; and
- drive greater consistency in the quality investigations."

Achieving these ambitions requires careful design of this new organisation. This includes:

- A clear focus on learning and safety improvement – there are multiple avenues and bodies which undertake incident investigations in the NHS. These have various objectives, but HSSIB stands alone in having an absolute focus on learning, not blame, and on systemic risk factors. The evidence and experience of the NHS and across other industries is clear that a learning culture leads to significant safety improvements. HSSIB has a key role to play in fostering and enabling a learning culture within the NHS.
- Evidence gathered within a safe space – this encourages and enables openness and learning. There is a strong connection between 'psychological safety' and a culture of learning – to open up and be candid, people need to feel confident that the information they share will not be used unfairly or passed on.
- Clear criteria for considering an investigation – while HSSIB may carry out an investigation into the same incident as another body, HSSIB will not be duplicating any other given investigation.

It will have a systemic risk focus, grounded in a set of criteria used to determine whether there may be a pattern and whether an incident should become a reference event for an investigation.

- Limiting the number of investigations per year – HSSIB is expected to carry out around 30 investigations a year, which will ensure that it remains focused and prioritises effectively and that it carries out investigations to the appropriate depth.
- Independent, expert-led investigations – this enables objective and comprehensive analysis, and robust, credible, systemic-focused conclusions.

There is much to welcome in the ambition, innovation and drafting of safe space in the Bill – and much to improve. For HSSIB to be able to properly investigate the systemic causes of safety issues, and to harness the knowledge and insight of those involved, a legally protected and robustly respected safe space is essential. It is particularly notable that a core part of the design of safe space here is the protection people have in sharing information with HSSIB being counterbalanced by a compulsion to participate in HSSIB's investigations. It is paramount to respect those two aspects of compulsion and protection, and for participants to be aware of the basis on which they are taking part in an investigation and what the implications for them are. The boundaries of safe space must be clear, consistent and constant. If those taking part in the HSSIB investigation do not have trust in the safe space provided, there is a high risk that they will feel unable to share information fully and fearlessly. This will undermine the investigations carried out by the HSSIB, and how the HSSIB is intended to stand apart from other bodies in the health system. Therefore, we are opposed to allowing senior coroners to access safe space materials and support the revisions made in the other House.