Briefing: July 2021

Second Reading of the Health and Care Bill

The Nuffield Trust is an independent health think tank. We aim to improve the quality of health care in the UK by providing evidence-based research and policy analysis and informing and generating debate.

The 2021-22 Health and Care Bill is the biggest legislative overhaul of the NHS presented to the House of Commons for a decade. It will change how England's largest public service works locally, and how it relates to Parliament and the Government. This briefing, based on our research and analysis of emerging proposals over several years, presents the key points and issues on which we believe MPs should provide scrutiny.

Key points

- The new powers for the Secretary of State to direct the English NHS and to intervene in local service changes risk creating a health service where party political aims distort decisions or are perceived to. This could undermine trust and make for worse choices, as it has in the past.
- The Bill could see even minor local changes to NHS services anywhere in England sent to Whitehall for approval. This risks bogging down innovation and dragging ministers into decisions better left to local leaders.
- The changes to create a more cooperative NHS at a local level represent the right direction of travel. However, the local structures are complicated. There is a risk of gridlock where people do not cooperate well.
- By splitting the NHS into larger areas, the calculation that steers money to areas who need it more will be less precise. There is a risk that small areas with higher needs will lose out.
- The Bill does very little to address the severe and worsening crisis in social care. The admirable goal of the NHS working better with social care will not be achieved if the sector is failing to deliver basic support and protection, as is the case today.

- New Integrated Care Boards have many important powers to take on, and a complex structure. Putting them fully in charge over the next few months may be difficult during the ongoing pandemic.
- The requirement for the Secretary of State to describe who is in charge of the NHS workforce is not very helpful, and should be replaced by a duty to carry out independent calculations of whether policies will make enough key workers available or not.

Changes to how the English NHS works locally

The Bill will overwrite the current local structure of the NHS, where local Clinical Commissioning Groups pay NHS trusts and others to provide care in what is meant to be a competitive "internal market".

Instead, under clauses 12 to 25 of the Bill, representatives of trusts, GPs and councils will sit together on the boards of "Integrated Care Systems" responsible for overseeing health services in 42 regions. Each of these will also have a wider partnership committee making plans for greater cooperation across health and social care.

The shift away from a marketised way of working also includes clause 68. This drops the current procurement rules which set out when services need to be advertised generally for any supplier from the NHS or private sector, replacing them with guidance. The draft guidance suggests it will become easier not to open contracts up to the market. These changes have already begun, with the NHS since 2014 increasingly working around the pro-competition legal framework.

NHS England will have a new power to limit how much capital trusts can invest in buildings and equipment. There are protections for patient choice in clause 67 which are welcome.

We believe the general direction of travel is right. Care does need to be joined up better. Going with the grain of what the service is doing is a much better approach than trying to drive revolutions from Whitehall.

It is important not to assume that these legislative changes will directly make reform or change happen: at best they might help the shifts in culture, workforce, and funding which will make a real difference.

There are a number of risks to be considered. In each area there will be:

- an Integrated Care Board with trusts, GPs and councils on its board as a minimum, controlling the NHS purse strings, setting regularly revised five year forward plans and publishing annual reports;

- Health and Wellbeing Boards at county or unitary council level conducting "joint strategic needs assessments", commenting on the plans of the larger ICB, and creating "joint local health and wellbeing strategies" alongside the NHS;
- An Integrated Care Partnership with representation from the Integrated Care Board and all relevant local authorities, as well as other relevant local organisations such as charities and housing associations, tasked with creating integrated care strategies reflecting the strategic needs assessments, and which the ICB and relevant local authorities in turn must have regard to.

Although the intentions are good, this complex, overlapping structure might lead to gridlock. In areas where relationships are not very good the different players locally, each with their own legal duties to follow, could resist any changes that go against their interests through the multiple different planning and consultation processes. These processes may take up a great deal of NHS managerial time.

Because these regions are typically four to five times larger than the commissioning group areas that existed before, there is a risk that money will not be allocated as precisely to areas with higher need – for example, poorer areas. Funding might just keep going to the parts of an ICS area which were better funded before, or might reflect the interests of stronger trusts or trusts with financial holes to fill, rather than being steered by a calculation of people's needs.

The end of the model where separate bodies – CCGs and their predecessors – held trusts and private providers to account should create a more collaborative healthcare service. But it also means that there is no independent local organisation overseeing and scrutinising services.

Under the current system, NHS foundation trusts which are efficient can build up reserves to invest as they want, rewarding them for good performance with the chance to upgrade their facilities and services. We are worried that the new model of caps on investment imposed from the centre discourages trusts and their staff from going the extra mile to gain improvements.

The timetable for all these changes - planned in 2022 - also needs to be kept under review: it may be unrealistic for a service reeling from Covid-19. The new ICBs will have to take on an enormous range of functions including planning and funding most health services (clause 15), promoting waiting times standards, improving quality, supporting research and training and reducing inequalities, and managing and limiting investment spending (clause 19).

The scale and complicated, even bureaucratic nature of these changes may risk distracting NHS managers and GPs from the urgent task of remodelling services and tackling unacceptable waiting lists due to the pandemic. Conversely, intense day to day demands may

mean the new structures are not set up with due care and attention. It will be important to ask how this potential clash will be monitored by the DHSC and NHS England, what the criteria would be to delay some of the changes, and how this would be done.

While this is not clear within the Bill or its explanatory notes, the underlying White Paper makes it clear that many of the powers of ICBs are supposed in fact to be delegated to smaller areas described as "places" – in many cases, these would be the same as a local council area. There is little detail on how this will work. Although there is a good case for flexibility to suit different regions, this adds another layer of complexity.

The fact that many decisions are supposed to be made at "place" level, and that NHS trusts will also remain with their own boards and budgets, means ICBs will not necessarily have the financial or operational control to go alongside their long list of duties. This may mean ICBs will hesitate to devolve power, or that they will find it difficult to make their strategic plans a reality. It may make it hard to answer the question of who is really accountable for decisions.

Important questions for scrutiny

Who will be on the new boards and how will they still hold local systems to account?

What is the risk of disruption or distraction? How will this be monitored and addressed?

Will taking away NHS foundation trusts' right to store up and invest their own money mean they are no longer incentivised to be efficient?

How can money still be precisely allocated to the places with highest need when the NHS moves to working in larger, region-sized units?

New powers over the NHS

The Bill will increase the power of the Secretary of State over NHS operations in several ways. We are concerned that these new powers will result in a more politicised NHS, with ministers dragged into micromanaging how local services work.

Currently, if local changes to NHS services are controversial, councils can refer them to the Secretary of State. Schedule 6 of the Bill would instead mean that the Secretary of State can intervene and change or block even minor local proposals at any time.

Under paragraphs 2 and 3, local or national NHS bodies must notify the Secretary of State of any change in "the manner in which a service is delivered to individuals", or even

circumstances that might result in this happening. He or she can then change or overwrite any decision. Once any decision has been "called in" by the Secretary of State, any changes must be frozen until the decision has been taken in Westminster.

We are concerned that this will mean minor local NHS reforms end up in politicised national battles fought at the level of the Secretary of State, causing gridlock at best, and at worst a perception of favouritism in where hospitals and other services are located, and which are closed down.

In the past, Health Secretaries under political pressure blocked changes now regarded as having saved lives - for example, the stroke care reorganisation in London. Political goals are not necessarily always aligned with the best interests of patients, something successive governments have recognised by creating independent responsibilities in the NHS. Ministers in Whitehall responsible for hundreds of decisions are not as well placed to understand each one as local leaders or councillors.

We would recommend that a degree of filtering should be reintroduced, with local councils or an independent body reviewing which cases are contentious. The White Paper raised a criticism that the previous system came too late in the process, which could be altered. The Secretary of State should also receive independent advice to reduce the perception of politicisation and have clear criteria based on which to take decisions. The White Paper suggested that this would be part of the new system, and we welcome the intention in the Explanatory Notes to retain an independent reconfiguration panel, but these provisions do not appear in the Bill itself.

While under the old system the process was encoded in regulations subject to parliamentary scrutiny, the new system would simply allow the Secretary of State to issue guidance.

Part 3 of the Bill gives the Secretary of State the power to move responsibilities between several major arms-length bodies in health, and to abolish them. This would extend to a power to change how the staff and chair of a body are appointed. Organisations like NHS England and NHS Digital are major public bodies with national responsibilities, some of which, like control of confidential patient data, are highly sensitive.

There is a case that changes of this magnitude should take place by primary legislation, but we welcome the Bill at least making them subject to the affirmative procedure (clause 131).

Clause 37 of the Bill would give the Secretary of State a general power to direct NHS England in the exercise of any of its functions. He or she would also have the power to declare NHS

England to be failing to discharge a function if it did not follow a direction. This would enable that function to be removed from NHS England, and transferred to the Secretary of State or any other person the Secretary of State chooses.

In both cases, directions or judgements of failure would need to be published along with their justifications, but not subject to parliamentary scrutiny or any other processes or requirements. The appointment of staff and treatment of individual patients would be exempt from direction, but powers regarding services, data, purchasing, targets, and local NHS bodies could be directed. The Secretary of State can direct NHS England as to the provision of drugs, medicines and treatments, but only if this does not contradict guidance or recommendations from the National Institute for Health and Care Excellence.

Separately, the Bill would also require the Secretary of State to approve the people appointed as Chairs of each ICB.

Secretaries of State already have power to set goals and standards for the health service. We are concerned that these powers might lead to micromanagement and the politicisation of operational decisions. We recommend that at the very least:

- The basis on which the Secretary of State could issue directions should be included in the Bill, for example by requiring that they must be consistent with the best interests of patients.
- Directions should be subject to some form of review or parliamentary scrutiny.
- The Secretary of State should not be able to transfer powers to any other person they choose if NHS England fails to comply with a directive.

Taken together, the powers over reconfiguration and direction point towards a health service where politicians in Westminster have much more power over decisions. We see a real risk that politicians under successive governments will feel pressure to distort decisions about services, staff and treatment to meet political goals. This could have result in a loss of trust from the public, and in bad choices taken for the wrong reasons.

To some extent this will return the NHS to a more politicised past – when, in addition to blocking service changes that with hindsight have proved to be clinically valuable, different governments appear to have changed the system for dividing money to areas of England to favour their political strongholds. In some respects, the level of political control could be greater than in previous decades when the health service was run through a government department, because of the lack of processes or limits around intervention in service change, and the lack of the Civil Service Code preventing politicisation in arms-length bodies.

Important questions for scrutiny

Is it really useful for every change to local NHS services in England to be given to the Secretary of State for consideration or veto? Is this going to increase innovation, or slow it down?

Why is it desirable for Ministers to have greater operational control over NHS services, rather than setting aims and goals for professional leaders to carry out?

Is there a risk that Ministers will feel a political imperative to take decisions that are not best for the long term running of the NHS?

Should there be some criteria in the Bill based on which the Secretary of State should take decisions about directing the NHS?

Are there any further areas of NHS policy which should not be subject to direction by the Secretary of State at will?

What is not included in the Bill

Clause 33 of the Bill creates a duty for the Secretary of State to report every five years on who is responsible for securing enough NHS staff. This report would simply describe the system that exists. It would do little to improve workforce planning. Along with the King's Fund and Health Foundation, we have suggested instead a proposal that would introduce independent forecasts of how many staff there will be and how many will be needed, in both health and social care. We believe this would provide accountability and help planning.

The Bill also includes several minor changes around social care, which do not constitute significant reform. New powers in Part 2 to collect information may be useful if they are deployed carefully, as data is lacking about the sector. There is also a new duty for the Care Quality Commission (CQC) to assess how well councils are fulfilling their social care duties.

The social care system in England is currently in a state of crisis, highlighted by the terrible effects of the pandemic. Our analysis shows that 163,000 people aged over 65 in England need help with three or more activities of daily living but receive none at all, from friends, family or professionals. The true figure, counting younger disabled adults, will be higher. Those who do access care by paying themselves can run up catastrophic costs with no protection. The social care workforce faces high turnover and vacancy rates, likely due to poor pay, terms, and conditions. Low fees have pushed many care homes and agencies who send carers out into bankruptcy or refusing council

contracts: the number of care home beds in England has actually fallen since 2015 despite a growing and ageing population.

A much wider set of reforms is needed which gets help to more people in need, makes the costs to individuals fair, straightforward and consistent, and allows providers and the workforce to stabilise. Without this being in place, the CQC is likely to simply find local authorities who have been forced into systemic failure through no particular fault of their own, rather than being able to productively hold councils to account to do better.

The reforms to the NHS described above are also premised in part on it being able to work with a functioning social care system. Without this, their structures for joining up care will struggle to work with a sector which cannot even provide basic requirements.

Important questions for scrutiny

Is a regular report on who is responsible for NHS staffing very helpful? Will the Government consider legislating for independent analysis of whether there will be enough instead?

How can social care cooperate with the NHS to create a better system when it currently lacks the money or staff to provide basic care to people who need it?

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