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BILL WATCH

STATE OF PLAY:
A REVIEW OF THE HEALTH AND CARE BILL'S PASSAGE THROUGH THE COMMONS

INTRODUCTION

Since its publication in July, the Health and Social Care Bill has sparked excitement and debate within health policy circles as it passed through its first round of scrutiny in the House of Commons. This week, the Bill is in the Lords for its second reading, marking the first major opportunity for Peers to debate its principles and purpose. Members, it's worth remembering, that now include Lord Stevens of Birmingham, the former NHS England chief.

So far the Bill has not disappointed in generating headlines about stealth privatisation, the NHS being sold to America and the "denationalisation" of our national treasure, as well as the slightly more curious sight of another national treasure, Stephen Fry, becoming the face of a campaign called 'Your NHS needs you!'.

The progress of the Bill so far can be characterised as having generated more heat than light. Thoughtful amendments have perhaps become lost amidst the noise. As **Isabel Hardman said in the Independent** recently, "If the Tories really wanted to privatise the NHS, you think they'd have managed it by now."

"IF THE TORIES REALLY WANTED TO PRIVATISE THE NHS, YOU THINK THEY'D HAVE MANAGED IT BY NOW."

Isabel Hardman, The Independent

As the Bill moves to the upper chamber, there are a few areas where Government has so far resisted the opportunity to accept amendments that might have made a tangible difference, where it might be hoped that the Lords intervene. Jeremy Hunt's niche amendment on workforce forecasting, blocked by the Government **allegedly because the Treasury thinks it would cost too much**, is one such reform that Peers may wish to adopt.

The Lords might also want to take a close look at the additional powers given to the Secretary of State, an area where scrutiny is encouraged by both the King's Fund and NHS Confederation, amongst others.

It is likely that Peers will drill down to the important issues, and prioritise pragmatic amendments which will improve the Bill before it returns to the Commons. This briefing – the latest from MHP Health's team of wonks – intends to cut through the noise and deliver a summary of the most important issues that were raised during the Bill's passage through the Commons and likely what the Lords' debate will focus on.

MADDY FARNWORTH
Director, Health

THEME 1

POWER OF THE SECRETARY OF STATE

One of the key areas of contention is the powers given to the Secretary of State for Health and Social Care. The Bill outlines 138 new powers created for the Secretary of State to give directions to the newly merged NHS England. This has fuelled concerns from NHS bodies and opposition members of a "power grab" that would enable the Secretary to intervene on the configuration of local services, the running of the NHS as well as minor local plans.

NHS Confederation has urged policymakers to question what they, the Health Secretary, service providers and patients would stand to gain from giving the Secretary of State such significant powers over clinical decisions. During an evidence session, Matthew Taylor, Chief Executive of NHS Confederation explained as to why the powers are not needed, noting "the risk with this element of the Bill is that we will end up with more politically motivated decisions which erode the NHS' clinical independence." He described the powers of reconfiguration as the Bill's 'Achilles' heel', stating "for the Secretary of State potentially to be embroiled in making decisions not just about major reconfigurations, but really relatively minor reconfigurations runs the risk not only of delaying necessary changes in the system, but of putting less emphasis on the views of local people and of clinical advice." This is of particular concern with recent news of the huge NHS backlog – as the ability to intervene with local decision making could slow down the ability of local systems to tackle their waiting lists.

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>
> **Matthew Taylor, Chief Executive of NHS Confederation**

Saffron Cordery, Deputy Chief Executive at NHS Providers also gave evidence, adding that "often, Secretary of State powers may seem like small elements, but taken together, the cumulative impact can be seen to erode that local accountability" and that "it is this central-local relationship that is absolutely critical to those who are working on the frontline". When providing his evidence, Chaand Nagpaul, Council Chair of the British Medical Association explained the concerns about the local reconfigurations and how politically sensitive these can be. He stated, "We would not want the Secretary of State to have disproportionate powers in those arrangements, which will often be more susceptible to political influence."

During debate of Clause 37 which introduces powers for the Secretary of State, Edward Argar, Minister of State for Health (Con, Charnwood), tasked with defending the shift in powers to the Secretary of State, explained that the powers introduced would ensure "the appropriate balance between democratic accountability to the Secretary of State and the NHS's clinical and day-to-day operational independence". He added that the clause does not give the Secretary of State power over other NHS bodies nor clinical decisions.

Throughout Committee stage, many of the amendments tabled to soften the powers created for the Health Secretary were not agreed to or added. Notably, Steve McCabe MP (Lab, Birmingham Selly Oak) tabled two amendments: the first which would require the Secretary of State to consult any relevant Health Overview and Scrutiny Committee (as defined by Amendment 102), and to have regard to and publish clinical advice from the Integrated Care Board Medical Director, before intervening in local service reconfiguration; and the second which would require the Secretary of State to publish a statement demonstrating that any decision they have made on a reconfiguration proposal is in the public interest. However, both amendments were not called.

Further reaction from the opposition has challenged these powers' ability to 'undermine the operational independence of the NHS'. Current Shadow Minister for Health and Social Care, Justin Madders MP (Lab, Ellesmere Port and Neston) has commented that Labour want "the Secretary of State to be both politically and operationally responsible for the health service, but not in the way this bill is framed – where he can pick and choose when to interfere, almost certainly on party political grounds."

Much of the external commentary questioned why these powers have been created and for what purposes they would be exercised. As Clause 37 was debated, Edward Argar outlined section 13ZC sets out specific areas for power and direction to be given to NHS England and that proposed new section 13ZD also sets out specific areas where the power of direction in section 13ZC cannot be used, including any function relating to the services to be provided to an individual's diagnosis or treatment or in relation to the provision of any medicine, treatment, or diagnostic technique. The King's Fund has argued that much more specificity is needed on the scope of these powers to protect the operational and clinical independence of NHS England.

The increased powers for the Secretary of State for Health and Social Care to intervene in local service reconfigurations ultimately require the Health Secretary to be notified of all NHS service changes, no matter how big or small, temporary, or permanent. This risks a back-log of changes piling up and severe delays to decision-making while these are addressed, placing a burden on local bodies awaiting a decision and a delay in changing to services that could benefit patients. The broadened powers have also been criticised for undermining the objective of the reforms to reduce bureaucracy and empower local decision-makers by increasing ministerial involvement in services. Health leaders are concerned that if these powers remain in the bill in their current form, they will undermine progress towards integration, transparency, patient safety and quality of care.

It is worth noting that these additional powers are ones that it was thought the previous Secretary of State had been particularly keen to gain, and there is less certainty as to the extent to which they are important to his successor.

THEME 2

ICS STRUCTURES AND ACCOUNTABILITY

The Health and Social Care Bill legislates for the creation of Integrated Care Systems (ICSs) as local partnerships of providers, commissioners, local authorities and other local partners. ICSs will plan healthcare services to meet the needs of the population in their 'patch'. As stated in our earlier MHP Analysis on the Bill in July this year, these changes represent an evolution of thinking, not a revolution. There is general support from both sides of the Chamber and from stakeholders outside of Westminster for a legal 'solidification' of collaborative, not competitive, provision of healthcare, particularly to address long-term systematic issues, such as widening health inequalities and lacking preventative healthcare.

It is perhaps unsurprising, then, that reactions and amendments to the bill are not wholesale, but instead focus on the detail of *how* these changes should be implemented. Recent amendments suggest there are several key areas of focus for Government, opposition, and external stakeholders; mainly around commissioning, research and power of ICS bodies.

The Bill introduces two bodies that form the ICS – the Integrated Care Partnership (ICP), responsible for bringing together a wider set of system partners to develop a plan to address the needs of the population and the Integrated Care Board (ICB), taking on the function of CCGs and some commissioning responsibilities from NHSE. ICBs will be accountable to NHS England for local services' operational and financial performance. The key premise behind this change is to ensure that ICSs represent a partnership between commissioners and providers to collaborate over the provision of services to their geographies.

This move has been broadly supported in the House, and by key provider bodies (NHS Providers, the Local Government Authority, and others) as it seeks to facilitate greater integration in healthcare and help each ICS deliver on their core purpose (to improve outcomes, tackle inequalities, enhance productivity and drive broader and economic development). However, Minister of State for Health, Edward Agar, tabled an amendment that would see primary legislation referring to CCGs continuing to operate, even after ICBs are established. This tells us that we can expect the changeover to be slow and a little bit messy.

It is also important to note that not all commissioning will be conducted by the ICB. There are a range of provisions in the Bill that allows NHS England and ICBs to work together in different ways to commission services, similar to Section 75 arrangements[1]. It will be important for this relationship to be ironed out and that NHS and local commissioning are aligned. DHSC will need to ensure that any measures to reduce requirements on the NHS do not inadvertently create barriers elsewhere in the system.

Following the COVID-19 pandemic, many have seen the introduction of the Bill as an opportunity to ensure that provisions for research are included in the legislation, to ensure that the prioritisation of clinical research begins from the bottom up, at a local level. This is particularly evident in Anne Marie Morris MP (Con, Newton Abbot) tabled amendment, that proposed that an Integrated Care Partnership must support research programmes within its catchment area, considering the efficacy of new and existing medicines, devices and public health and social care.

[1] Section 75 of the NHS Act 2006 allows partners (NHS bodies and councils) to contribute to a common fund which can be used to commission health or social care related services.

Further, the ABPI recently produced a new report, **Clinical research in the UK: an opportunity for growth**, which argues that the new Health and Care Bill should mandate that Integrated Care Systems ensure that NHS organisations, for which they are responsible, conduct and resource clinical research. This will be key to the UK's ability to restore its healthcare system post COVID-19 and embed new and innovative ways of working, while also growing its capacity to deliver clinical research.

This signifies the extent to which the narrative around research has changed; historically, changes to improve clinical research processes have been hard won, or not won at all. However, these amendments signify a national prioritisation of research and a willingness to work with industry to ensure that the UK is seen as a leader in life sciences.

There have been ongoing questions about where power will lie under the new changes, not only within ICSs but more broadly in the new system.

The strategic direction for each ICS will be set in partnership between the ICB and the ICP, with the ICB responsible for commissioning and the ICP to sit alongside as a joint committee focusing on broader health and care services. The ICB will have a chair, chief executive and representatives from local NHS providers, primary care services and local authorities, and control over and accountability for NHS resources. Based on the information in the Bill, and associated commentary, it is unclear exactly what the role of the ICP will actually be, and how it will complement or influence the ICB. As the King's Fund has stated, it will be in how these two bodies interact as to where power will lie within the ICS. This will come down to the personalities that form each group, and the influence of the regional directors. There will likely be examples of both ICB and ICPs exerting influence in time, but the ICB seems to have more structure and purpose instilled within it from the legislation, than the ICP.

THE SECRETARY OF STATE WILL HAVE NEW AND FARTHER-REACHING POWERS THAN PREVIOUSLY EXISTED, AS DISCUSSED ELSEWHERE IN THIS ANALYSIS, AND WHILE ICSS ARE BUILT AROUND THE FOUNDATION OF 'COLLABORATION', IT WOULD BE NAÏVE TO EXPECT THAT THIS WILL WORK EQUALLY, OR EVEN EQUITABLY BETWEEN PARTNERS

THEME 3

WORKFORCE

In addition to the new scope of powers afforded to the Secretary of State, measures are also included to ensure health service workforce needs are assessed and are meeting standards in England. Clause 35 of the Health and Social Care Bill (as it now stands in the Lords): Secretary of State's duty to report on workforce systems, will ensure this, with the Secretary of State required to publish a report every five years on workforce systems.

Although more accountabilities have been put on the Secretary of State, and additional clarity around system needs and workforce planning will be now available, the timings of the report delivery was fiercely contested among MPs. The amendments tabled and debated against this clause had a strong focus on timelines and clearer specificities around what reporting should inform.

With the clause requiring that reporting should occur every five years, or once a parliament, health and social care organisations criticised that these timeframes were too loose. During Committee Stages, Chris Skidmore (Con, Kingswood) on listening to oral evidence given by witnesses, addressed these concerns and raised amendment 94. The amendment would require the review and reporting of current and future workforce numbers every two years and would be based on Office for Budget Responsibility economic projections and other forecasts including demographic changes, prevalence of different health conditions, and the likely impact of technology.

Additional amendments 40 and 41 were also tabled by the opposition and included tighter parameters and timings on workforce reporting. In addition to reduced timelines, amendment 41 required that Health Education England publish an annual report on projected workforce shortages and future staffing requirements. Additionally, amendment 85 was tabled by Hywel Williams (Plaid Cymru) that required the Secretary of State to consult Welsh Government prior to when workforce functions in the clause are exercised. Following debate, both amendments 94 and 85 were withdrawn, and amendments 40 and 41 were negatived on division.

Amendments in relation to additional workforce and staffing issues were also tabled. Justin Madders (Lab, Ellesmere Port and Neston) moved amendment 43, which would legislate the already current practice of NHS bodies honouring staff pay and conditions. This amendment was also rejected following a division.

Externally, leaders across the health and care sector have stressed the need to strengthen workforce planning within the Health and Care Bill and supported amendments tabled during the Bill's legislative process. There is a consensus that the Bill has missed a glaring opportunity to improve workforce planning against the backdrop chronic workforce shortages and the need to meet the Government's 'Build Back Better' agenda.

General Secretary & Chief Executive of the Royal College of Nursing, Pat Cullen explained to the Health and Care Bill Committee that the Bill doesn't address workforce shortages enough. Ms Cullen stated that even prior to the COVID-19 pandemic, there were 40,000 nursing vacancies. This shortage of staffing was also echoed by David Wrigley, Deputy Chair of the British Medical Association, who argues that there is a shortage of around 50,000 doctors. Mr Wrigley in his article titled, **"Wrong Bill at the wrong time"** also stated the Bill fails to go far enough in addressing years of underinvestment of the NHS and its other surrounding issues.

Understaffing is also considered by NHS providers, who quote that "while it is encouraging to see that the numbers of doctors and nurses has risen again…the number of staff shortages also continues to grow, with the NHS now having over 99,000 vacancies… the NHS is spending a staggering £6bn a year on temporary staff to plug gaps".

"WITHOUT AN ADEQUATE WORKFORCE, IT WILL BE VERY DIFFICULT TO DELIVER ANY OF THE AMBITIONS OF THE BILL"

Professor Martin Marshall, Chair, Royal College of GPs

Ahead of the report stage, former Health Minister Jeremy Hunt (Con, Southwest Surrey) tabled an amendment to now clause 35 of the Bill that again would require the Secretary of State to publish workforce reports every two years that would, however, have to be independently verified and be consistent with Office of Budget Responsibility long-term fiscal projections. Mr Hunt was supported by 18 members within his own party, and by over 60 organisations and charities, including the Royal College of Physicians, the British Medical Association, the Royal College of Nursing, NHS Providers, NHS Confederation, and Macmillan Cancer support. The amendment was also supported by members of the opposition including then Shadow Health Secretary, Jonathon Ashworth (Lab, Leicester South). The amendment was ultimately voted against, possibly due to budgeting and cost implications.

Despite no amendment being moved against now Clause 35, there is still a consensus from health and care organisations that there is an urgent need to strengthen legislation for future proofing NHS staffing. Professor Martin Marshall, Chair, Royal College of GPs summed up the situation best during his witness examination at Committee Stage – "Without an adequate workforce, it will be very difficult to deliver any of the ambitions of the Bill".

THEME 4

HEALTH INEQUALITIES

Cited as a priority of NHS England since the publication of the Long Term Plan in 2019, the subject of health inequalities has gained huge traction across Government, Parliament and the media since the onset of the COVID-19 pandemic. However, in spite of its gravitas, when compared to existing NHS legislation the Bill's provisions to support action on health inequalities does not mark a change from the existing legal framework. Of the tabled amendments to strengthen the Bill's mandate on health inequalities, none were accepted. This is concerning given progress against national NHS commitments to reduce health inequalities has been slow in recent years.

During the passage of the Bill through Commons, Conservative MPs frequently addressed health inequalities alongside the creation of Integrated Care Boards (ICBs). The responsibilities placed on ICBs for collecting accurate patient data, promoting public health and enabling joined up working across providers would allegedly position these boards with a unique understanding of population health, allowing ICBs to direct resources towards the factors driving disparities in health outcomes. With these responsibilities in mind, on rejecting amendments seeking explicit commitments on health inequalities in the Bill, Conservative MPs repeatedly argued the subject falls within the existing proposals in the Bill on Government and NHS duties.

During an early committee session, Labour MPs called for the modification of the triple aim of the Bill to "explicitly require NHS England to take account of health inequalities when making decisions". This sentiment has been echoed by think tanks such as The Kings Fund and The Health Foundation, with the former commenting that omission will be 'repeating the mistakes of the last decade'. On voting down the amendments to Clause 4 which would enact this change, Edward Argar, Minister of State for Health, contended that health inequalities were covered by the duties of ICBs, the Secretary of State for Health and Social Care and the newly created Office for Health Improvement and Disparities. To a similar effect, amendment NC13 calling for the Secretary of State to set five-year targets on population health and the reduction of inequalities was not called by the Committee.

On the Government benches, Chris Skidmore (Con, Kingswood) cited tackling health inequalities as an objective of two separate clauses on research. These clauses stated the need for joint working between the Secretary of State, the wider public sector, universities, and other research settings to ensure decisions on improving NHS services would be derived from data on population health. However, the clauses were withdrawn on the basis of the existing statutory duty allegedly championing research and ensuring its findings are put to use.

Further concerns of widening inequalities were sparked following the change to the cap on social care costs approved by the House of Commons in November and folded into the Bill via a new Clause at Report stage. The new legislation caps the individual cost of care at £86,000 and specifies that local authority funding support (means tested grants support) will not be accounted for within the £86,000. The decision has provoked criticism from the Opposition benches that the main beneficiaries of the reform would be people with higher assets, while those with lower assets risk losing a high proportion of their assets including the value of their property. It is of note that this cap applies to England only.

Whilst legislation can only do so much to reduce health inequalities, the Bill marks an important opportunity for more tangible NHS action. The new structure promoting integration with local authorities is a welcome move for encouraging collaboration. However, there is a worry that in the absence of explicit mandates of health inequalities at natural entry points eg 'triple aim' and core inequalities duties, Integrated Care Partnerships (ICPs) may be side-lined by more powerful NHS agencies. Ultimately, given that the Bill only transposes existing inequality duties onto the new ICBs, there is good reason to argue that it does not go far enough to improve accountability, and misses simple but significant opportunities to signal the importance of health inequalities as a health system priority.

External commentary on changes to the social care cap has emphasised the disproportionate disadvantage of the cap on less well-off households compared with wealthier households. The Kings Fund commented that "It's not that poorer people are paying more than wealthier people. It's that poorer people are paying the exact same amount for their care as wealthier people". Age UK warns that the changes "fly in the face" of the Government's levelling up agenda and benefit people with more valuable houses living in the South. From a health inequalities standpoint, the reforms risk widening the yawning gap between wealthier and poorer households and communities, with knock-on effects on needs and access to healthcare according to affluence.

Further White Papers on integrating health and social care and prevention and health inequalities are expected next year. It is therefore imperative that clarity is sought on how the various reforms will work together.

"IT'S NOT THAT POORER PEOPLE ARE PAYING MORE THAN WEALTHIER PEOPLE. IT'S THAT POORER PEOPLE ARE PAYING THE EXACT SAME AMOUNT FOR THEIR CARE AS WEALTHIER PEOPLE"

The Kings Fund

SOCIAL MEDIA ROUNDUP

Period of analysis: 1 September – 23 November 2021
Searches conducted via Meltwater using the search term: 'Health and Care Bill'

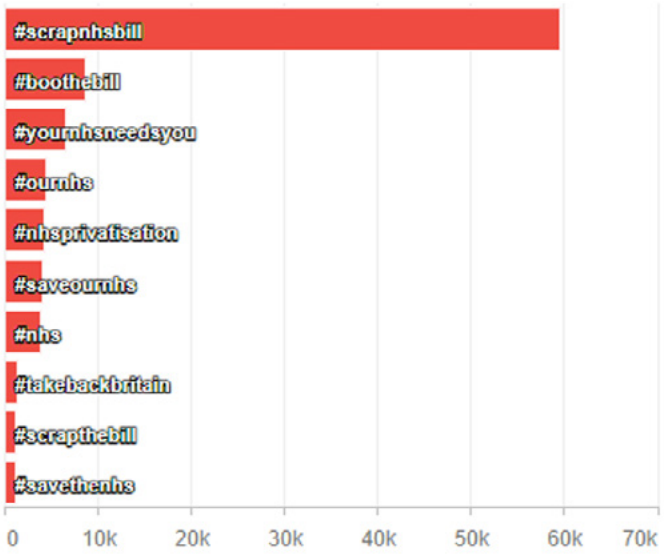
Social media interest in the Health and Social Care Bill really 'took off' following the launch of the #ScrapNHSBill campaign in mid-September. This grassroots movement is driven on social and is fiercely critical of the Bill, which campaigners contend is tantamount to 'rolling out the red carpet' for NHS privatisation.

Across all platforms, posts about the Bill garnered over 140,000 mentions, 355 million impressions with a reach of 63.1 million. The vast majority of these were related to the #ScrapNHSBill (or similar) posts.

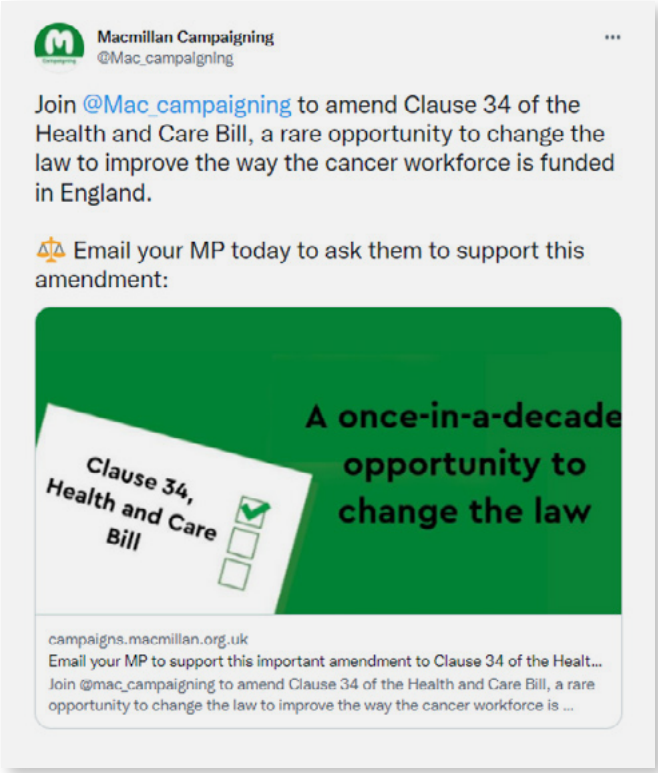
The most prominent posts related to the movement were the launch by campaigner JuJuliaGrace (3075 mentions) and the public billboard van protest outside VirginCare's HQ on 15 October (2089 mentions). On the parliamentary side, prominent left-wing MPs (Jeremy Corbyn, Zarah Sultana and Richard Burgon) tweeted about the Bill coming to the Commons on 16 November, which amassed 3470 mentions. On 22 November, the Government survived the Tory rebellion on social care costs, the news of which generated a massive 43.6k mentions.

Celebrity activism against the Bill also generated a large volume of social media interest, with a series of videos under the hashtag #yournhsneedsyou reaching a huge audience. Contributions from a diverse group of British celebrities, from Stephen Fry to Charlotte Church, Brian Eno to Johnny Vegas, received millions of impressions at a time (12.5 million for Stephen Fry, 11 million for Russell Brand, for example) leading to a total of 484 million impressions.

Top hashtags

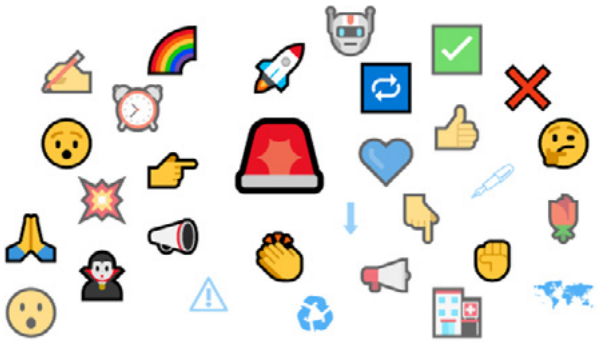


Amongst the noise of this campaign, nuanced conversations on twitter were taking place. Health policy commentators, journalists, think tanks and charities offered their 'take' on the campaign or on the specific provisions of the Bill and how they wanted it to be shaped during its passage through the Commons, although these were in the significant minority in terms of volume of coverage on social media. As the Bill continues through the Lords, it is likely that the trends will continue in the same vein, and likely be amplified in scale.



Top keywords

Top emojis



CONCLUSION

For perhaps the first and last time in a professional context, the words of Ricky Gervais spring to mind: "If you try to please everyone you'll please no one." With all of the noise, and individuals from all parties tinkering around the edge of the Bill to suit their interests, there is a risk that the debate misses the things that will make a tangible difference.

With that in mind, there are – from this long list of contentious issues and tricky nuances – two absolute priority areas the Lords must now seek to address.

Firstly, on the powers of the Secretary of State, the Lords should seek to table Amendments which clarify and/or specify the exact scope of the powers given to the Secretary of State to ensure the operational and clinical independence of NHS England and of local health systems is maintained.

Secondly, on the health and care workforce, the Lords should seek to table amendments which strengthen workforce planning and require more regular reporting informed by accurate projections of future workforce needs.

Beyond that, we will keep a close eye on any further amendments that boost powers of Integrated Care Boards in terms of clinical research. In our next Billwatch edition, we will also be identifying and making note of interventions by Peers who have a wealth of experience across the health care system – all of whom the Government will find hard to disagree with.

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