

# Health and care bill: report stage

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November 2021

## Background

Since the publication of the white paper, [Integration and innovation: working together to improve health and social care for all](#), in February 2021, the NHS Confederation has continually engaged with health leaders to hear their thoughts on the proposals.

Our members have told us that their key concerns about the bill are:

- 1) the proposed new powers for Secretary of State for Health and Social Care to become responsible, in law, for local service reconfigurations
- 2) the need for stronger checks to be put in place to assess and project future workforce needs across the NHS.

If you would like to have a further briefing from us, or if you plan to speak in the debate, please do get on touch with Caitlin Plunkett-Reilly, external affairs manager (public affairs) at [caitlin.plunkett-reilly@nhsconfed.org](mailto:caitlin.plunkett-reilly@nhsconfed.org)

## NHS Confederation view

The NHS Confederation largely supports the health and care bill. There is clear consensus across our membership that the future of health and care must be based on collaboration and partnership working at a local level.

The bill is largely based on recommendations from NHS England and NHS Improvement (NHSEI), as well as local health and care leaders, to remove legislative barriers to the local integration of care services, which is already underway.

In many ways, the legislation is catching up with what is happening on the ground. It is critical that this legislation is passed and given Royal Assent before April 2022. This will mean ICSs can function as statutory bodies, which will enable better and more efficient care for patients.

Our members agree that the Bill should be as permissive as possible to enable integration and local flexibility, rather than an overly prescriptive set of centralised rules. Their primary concern is the proposed introduction of unchecked new powers that would allow the Secretary of State to intervene in local service reconfigurations, despite there already being an established process in place for deciding on reconfigurations.

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.

## Secretary of State powers

The health and care bill introduces **significant and largely unchecked new powers for the Secretary of State (SoS) to intervene at any stage of a local service reconfiguration decision** (such as a change in location or the type of treatment provided by an NHS organisation), with no minimum set of information requirements on which to base such a decision. This risks **undermining progress towards integration**:

- The ability of hospitals, GP surgeries, clinics and other local NHS organisations to make important and sometimes difficult decisions about the services they provide is significantly reduced. This takes away local expert accountability, which is a key aspiration of the bill.
- Without clinical advice, local input, or public transparency over local service reconfiguration decisions, the quality and safety of patient care may be at risk.
- Making it easier for health and care services to work together and structure themselves around the needs of their local communities is critical to meeting rising demand for healthcare. Local health leaders are concerned burdensome ministerial intervention could impede the NHS's ability to tackle the treatment backlog caused by the COVID-19 pandemic and build back better.

## Our key ask

There is already a well-established process for considering proposed reconfigurations to local health services, involving extensive patient and public consultation and oversight by the government's Independent Reconfiguration Panel (IRP), after which the Secretary of State may 'call-in' decisions. **Although we welcome the continuation of the Panel, the proposed changes, as currently formulated, would override this process and thus local and clinical input.**

We are therefore urging you to speak in the debate to raise these issues relating to Secretary of State powers in the House of Commons at Report Stage.

David Simmonds MP and Sir Roger Gale MP have tabled the below amendments to Schedule 6:

**103) Schedule 6, page 186, line 4, at end insert—**

*““relevant Health Overview & Scrutiny Committee” means any Health Overview and Scrutiny Committee in an area to which the proposal for a reconfiguration of NHS services relates.”*

**104) Schedule 6, page 186, line 31, at end insert—**

*“(c) must consult relevant Health Overview & Scrutiny Committees.”*

**105) Schedule 6, page 186, line 43, at end insert—**

*“(b) have regard to, and publish, the clinical advice of the Integrated Care Board’s Medical Director in relation to any decision under subparagraph (2)(a), (c) publish a statement demonstrating that any decision made under sub-paragraph (2)(a) is in the public interest, and”*

These amendments would mean the Secretary of State would be legally required to consider clinical advice about changes to clinical services. It would also require him to consider the view of local health overview and scrutiny communities – ensuring accountability to local communities – and set out why intervention is in the public interest to ensure transparency.

We strongly urge members to **vote for amendments 103-105** to ensure local health leaders in their constituency are empowered to deliver services in a way that best supports the communities they serve, reduces health inequalities and ensures they can tackle the elective backlog as quickly as possible.

The proposed amendment is supported by the [Local Government Association](#), [Centre for Governance and Scrutiny](#), the [British Medical Association](#) and [National Voices](#).

## Case study: Secretary of State powers

### NHS Kent and Medway

The review of Kent and Medway's stroke services began in 2015, and a decision to implement three hyper acute stroke units (HASUs) was made by the Joint Committee of ten CCGs in February 2019.

Consultants involved in the reconfiguration estimated that a life a fortnight would be saved, with many more benefitting from reduced disability if three HASUs were established.

One of four local councils involved separately referred the decision to the then Secretary of State, who passed their referral to the Independent Reconfiguration Panel (IRP) for review and additional scrutiny. The IRP approved the changes in their advice in Autumn 2019, commending the local consultation process in their report.

The 'green light' decision was sat on the desk of successive Secretaries of State for two years. The current Secretary of State very recently approved the HASUs, endorsing in full the decision of the IRP. This shows there is a well-established process already in operation, and the Secretary of State does not need the new powers currently in Schedule 6 of the health and care bill.

## Workforce

We also strongly support the amendment tabled by the **Rt Hon Jeremy Hunt MP** regarding the duties on Secretary of State relating to **workforce (amendment 10)**.

The duty on Secretary of State in the Bill as it stands does not go far enough in ensuring we know we are training enough people to deliver health and care services that meet population need in the future. Rather than describe the system in place for assessing and meeting

workforce needs, this amendment would ensure regularly published assessments of future workforce needs, and a duty on government to respond to those projections with a plan for ensuring this demand will be met by the future health and care workforce.

We support this amendment, as do a broad coalition of health sector organisations, trade unions and clinical bodies.

In a recent snap poll of members, 87 per cent of healthcare leaders told us a lack of staffing in the NHS as a whole is putting patient safety and care at risk. This has jumped from 67 per cent in June this year.

The Health Foundation estimates the NHS workforce needs to increase by 40 per cent by 2030 in order to respond to population need.

The amendment would put a **duty on Health Education England (HEE) to publish robust, projections of the numbers** needed in **every medical specialty** and **the numbers we need to be training to meet these projections every 2 years**. This will then mean the Secretary of State will have to make a decision about whether to fund those places or not – the publication of the projections mean we can have a transparent debate about what is required.

Our members have long been very concerned about workforce pressures – this concern has only grown as the NHS faces an incredibly challenging winter and the ever-growing backlog caused by the pandemic. Most recently, nine in ten NHS leaders have told us that pressure on their local system is unsustainable. Just under nine in ten leaders say lack of staffing in the NHS as a whole is putting patient safety and care at risk.

NHS Confederation members have reflected that there are particular areas of the workforce which would be impacted by increased demand over the next 15 years: social care, primary care, adult mental health and learning disability services, children's services in community and mental health and diagnostic services.

The ability of the NHS to provide safe, quality care to patients is dependent on ensuring the workforce is available and able to deliver it. This amendment will go some way to ensuring it is. We strongly encourage members to **vote in favour** of it.

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## About the NHS Confederation

The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.