The Health Foundation

Briefing for MPs and Peers: Health and Care Bill

Tuesday 29th March 2022

House of Lords' amendments on workforce planning and social care costs must be upheld

The Health and Care Bill 2021/22 outlines major changes to NHS rules and structures in England. The Bill is the largest legislative shake-up of the NHS in a decade and undoes many of the changes introduced by the Coalition government in the last round of major NHS legislation back in 2012.

The Health Foundation has welcomed the Bill's broad emphasis on increasing collaboration between different parts of the health and care system. Although the benefits of these changes should not be overstated, encouraging collaboration to improve care makes sense and goes with the grain of recent NHS policy. We also welcomed the government's amendments to encourage a data driven approach to addressing health inequalities.

During Report Stage in the House of Lords, Peers voted to amend the Bill in two critical areas:

- workforce planning – Peers accepted amendment 29 to clause 35, requiring the Secretary of State to publish independently verified assessments of current and future workforce numbers every two years
- social care cap – Peers rejected the government's amendments to the Care Act, which would put more people at risk of catastrophic care costs.

This briefing sets out why these decisions should be upheld as the Bill returns to the House of Commons. It also outlines our analysis of other key proposals within the Bill, including increased powers for the Secretary of State, the establishment of Integrated Care Systems (ICSs), action to address inequalities, and improved data sharing.

Tackling workforce shortages

Workforce shortages are the biggest challenge facing the NHS and social care. If there are not enough staff to deliver extra services, the NHS will be unable to clear its record backlog and improve the quality of care. Failing to address workforce shortages would undermine recent investment in health and care.

Additional workforce needed for elective recovery in 2024/25

The current elective waiting list stands at 6.1 million. There are fears, though, that this understates the extent of the challenge. Millions of patient referrals that would have been expected didn't happen during the pandemic. If those patients return in significant numbers, the waiting list could yet grow significantly.

In September 2021, the REAL Centre projected that clearing the elective backlog, treating most missing patient referrals and returning to the constitutional waiting times target by the end of this parliament would require 4,400 additional consultants and 18,300 nurses. Since then, the Omicron wave has put the brakes on the NHS elective recovery, the number of missing patient referrals has grown, and time has been lost. To do the same by the end of the parliament would now require an extra 6,200 consultants and 25,700 nurses.

However, there remains a great deal of uncertainty, especially over returning missing patient referrals. The government in its elective recovery plan committed to a more cautious course of action based on tackling long waits and increasing activity by 30% compared to pre-pandemic levels by 2024/25. The NHS would also make greater use of advice and guidance and deliver fewer follow-up outpatient appointments. Even this would require a much larger workforce; the REAL Centre estimates this would need 14,000 more nurses and 3,400 more consultants than pre-pandemic.

Additional workforce needed for elective recovery in 2024/25

	Meeting 18-week constitutional standard by 2024/25				Elective recovery plan*
	Sept 2021 estimate	Updated	Sept 2021 estimate	Updated	
Returning missing patient referrals	75%		50%		50%
Consultants	4,400	6,100	3,000	4,200	3,400
Nurses	18,300	25,200	12,500	17,400	14,000

REAL Centre estimates based on RTT data and the Delivery plan for tackling the COVID-19 backlog of elective care

*Note, the numbers for meeting the 18-week target and for the recovery plan are not wholly comparable as they are based on different assumptions of underlying activity growth and how activity is delivered.

But this is only the elective workforce. As the Omicron wave has shown, rises in emergency demand and challenges discharging patients from hospital can severely constrain health care activity. The NHS cannot function optimally without addressing staffing needs across emergency and elective services, but also in community care, mental health, primary care, and adult social care.

The Health and Care Bill provides a major opportunity for the government to create a better system for workforce planning, yet the Bill currently falls far short of the action needed. Clause 35 puts a duty on the Secretary of State to publish a report describing the system in place for addressing and meeting workforce need every five years. Crucially, this fails to address whether the system is training, educating and retaining enough people to deliver services now and in the future.

We are supporting the amendment 29 to clause 35, which requires the Secretary of State to publish independently verified assessments of current and future workforce numbers every two years – consistent with the Office for Budget Responsibility (OBR) long-term fiscal projections. This would strengthen long-term spending decisions about workforce planning, regional shortages and skill mix based on evolving trends.

We are disappointed that the amendment has so far not been accepted by the government, despite support from over 100 health and care organisations, and the Health and Social Care Select Committee. In response to the amendment, the government has pointed to Health Education England's forthcoming Framework 15, which will review long term strategic trends for the health and social care workforce. However, Framework 15 will not solve the glaring data gap on health and care staffing numbers – which is crucial to inform strategic workforce planning decisions. Even after Framework 15, we will still not know how many NHS and social care staff we will need to meet growing demand now, or in future.

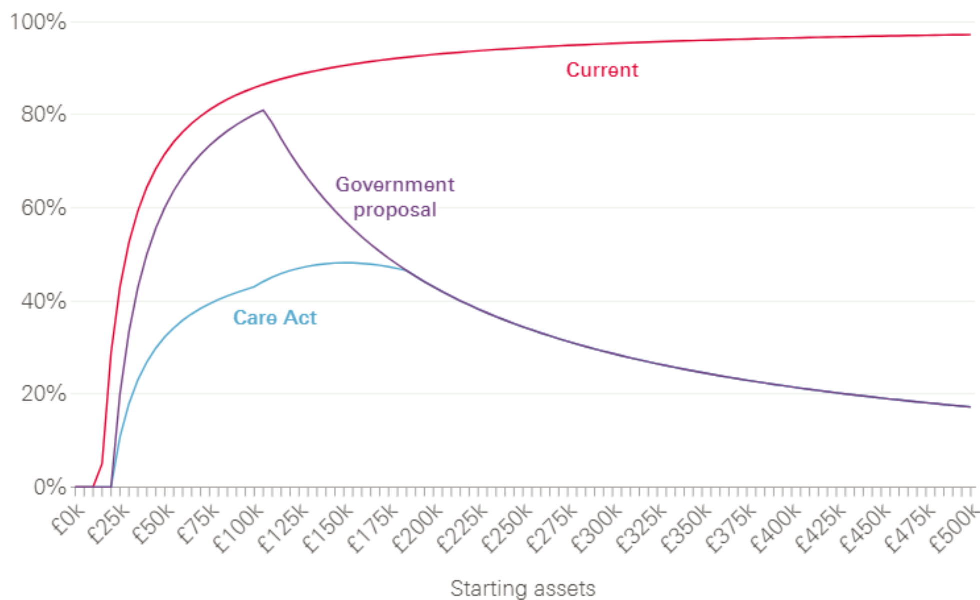
Failing to invest in workforce retention and expansion comes at a cost. In 2019/20, £6.2bn was spent on agency and bank staff in hospitals in England to plug workforce shortages.[1] Smarter long-term investment in the workforce presents opportunities to limit costs on short-term spending when services come under pressure.

The social care cap

The Health Foundation welcomed the government's plans to introduce a £86k cap on social care costs and to widen means-tested support to pay for care, supported by the Health and Care Levy. While the funding announced by government for social care falls well short of what is needed to stablise the current system and deliver comprehensive reform, the cap will protect people against the risk of very high care costs and provide them with greater certainty about the future.

In 2011, The Dilnot Commission recommended a cap on care costs of between £25k and £50k. The Care Act 2014 was passed to implement Dilnot's proposals, but successive governments have since failed to bring it into force. This government's planned £86k cap was already less generous than under the Care Act – but its proposed amendment to the Health and Care Bill further undermined its own ambition to protect people with lower assets from catastrophic care costs. By only counting private contributions towards the cap, and disregarding local authority contributions, those with wealth of less than £106k will be exposed to maximum care costs of almost twice the amount as under the Care Act. The Dilnot Commission considered this approach and rejected it as unfair.

The chart below shows people's maximum exposure to care costs, comparing the current system, the Care Act and the Government's proposed approach. Under the current system people can lose all but £14,250 of their assets. For someone with £100k this represents 86% of their wealth. Under the Care Act, this would be reduced to 43% maximum loss. But under the Government's proposals the maximum loss would be £80k – 80% of their assets. The proposals offer little protection against catastrophic costs for those with lower levels of wealth.



Members of the House of Lords made the right decision by rejecting the government's proposed amendment. When MPs originally voted in support of the government's amendment in November 2021 they were effectively voting in the dark, without a detailed assessment of the impact of the change. Research from the IFS and the Health Foundation has since shown that the government's change would leave more people worse off compared to the original reform proposals. Among older people, those most affected would be those with modest assets and wealth, and by region, those living in the North East, Yorkshire and the Humber, and the Midlands. It will also disproportionately affect working age adults with disabilities.

When we divide the population that is aged 65 and older into fifths, according to their wealth, those facing the biggest loss from the government's amendment are in the second poorest fifth (who have wealth per person of between £83,000 and £183,000). For this group, the government's plans would mean that 10 years in residential care would require spending an additional 10% of assets (or around £12,000), on average. This compares with almost nothing extra for people in the wealthiest 40% (those with assets of more than £298,000).

These changes are poorly conceived and a step in the wrong direction. They seem motivated by a desire to save money – but would do so by taking protection away from poorer older homeowers and adults of working age with care needs.

Now that MPs know that the Government's proposed amendment to the social care cap puts more people at risk of catastrophic care costs, we urge them to follow in the footsteps of the Lords and reverse what would be a regressive change and one that is opposite to it's ambition to level up.

Background on the Bill's other key proposals

Secretary of State powers

The Bill proposes giving wide ranging new powers to the Secretary of State. These changes lack rationale, are politically motivated, and warrant close scrutiny.

The powers would strengthen the health secretary's control over the day-to-day running of the NHS in England, including powers to direct NHS England – the national agency responsible for overseeing NHS planning and budgets – in relation to almost all its functions. They also include powers to intervene at any stage in service reconfigurations, such as decisions about merging or closing local hospitals. NHS leaders would be required to notify the health secretary about proposals to reconfigure services. And the Secretary of State will be able to 'retake' decisions already made by NHS leaders, as well as direct them to consider new service changes. The House of Lords supported an amendment to schedule 6, which changes the definition of a reconfiguration of NHS services to ensure that it only covers significant changes – which we support.

It is not clear how these changes will benefit patients – and they risk making things worse. Decisions about service changes are complex and evidence to inform them is often limited and disputed.[2,3] Independent judgment has been used to help reduce ministerial involvement in contested decisions.[4] Greater central intervention may also undermine the Bill's focus on giving power to local leaders to improve population health. Government should articulate clearly why they think these new powers are needed, what they plan to do with them, and what oversight will be in place to ensure decisions are made fairly and transparently.

Integration and collaboration

Under the plans in the Bill, every part of England will be covered by an 'integrated care system' (ICS). These currently exist informally in 42 areas of the country, serving populations of around 1 to 3 million. Each system will be made up of two new bodies:

- 'integrated care boards' (ICBs) – area-based NHS agencies responsible for controlling most NHS resources to improve health and care for their local population – and,

- 'integrated care partnerships' (ICPs) – looser collaborations between the NHS, local government, and other agencies, responsible for developing an 'integrated care plan' to guide local decisions.

Clinical commissioning groups (CCGs), currently responsible for purchasing NHS services, will be abolished and replaced by the new ICBs. Existing requirements to competitively tender some clinical services will be scrapped, though exactly what will replace them is currently unclear.

Overall, the emphasis on collaboration between the NHS, local government, and others through ICSs makes sense, and builds on recent national policy initiatives. But the potential benefits of greater collaboration – both within the NHS and between NHS and wider services – have long been overestimated by policymakers.[5,6] Making collaboration work also depends as much on culture, management, resources, and other factors as it does on NHS rules and structures.[7,8,9]

The new structure also risks being complex and vague. The relationship between NHS providers and the new ICBs is currently unclear. There is limited detail on how the new 'place' level of the NHS will be organised – and government's new white paper on integration between health and social care proposes additional changes at a 'place' level that may cut across the intended role of ICBs. ICPs also look as if they will play a bit-part role – responsible for developing an integrated care strategy (of which many similar local plans already exist) – and risk being side-lined by more powerful NHS agencies. This would undermine the Bill's aims for better integration of services beyond the NHS and limit the ability of local systems to tackle social and economic factors that shape health and health inequalities.

Establishing a new regional tier of the NHS in England, through ICBs, could improve the murky accountabilities in today's health system. NHS policymakers have a long history of reinventing the "intermediate" tier of the health service – and most national public health care systems have some form of regional management layer. But creating organisations is easier on paper than in practice: experience shows that merging and creating new agencies can cause major disruption. [10] There is limited detail on how the performance of newly established ICBs will be assessed and reported. There is also a risk that creating larger geographical units to manage NHS budgets leads to less equitable distribution of funding, depending on how decisions about allocating money with ICBs are made.

Reducing health inequalities

Covid-19 has exposed and exacerbated existing health inequalities in England, and the government has committed to 'levelling up' the country.[11]

As explored in our long read, when it was first introduced in the House of Commons the Bill's original provisions relating to health inequalities amounted to more of the same, and it needed to go further to tackle health inequalities.

Amendment on health inequalities data

To help drive more action and enable better tracking of progress across different areas of health inequalities, we proposed an amendment to require NHS England to publish guidance on collecting, analysing, reporting and publishing data on all factors or indicators relevant to health inequalities (see appendix). This amendment was selected for debate at Report Stage in the House of Commons and Committee Stage in the Lords but was not put to a vote.

Following Committee Stage in the House of Lords, the government proposed a related amendment (see appendix) requiring NHS England to publish a statement describing the powers of NHS trusts, foundation trusts and Integrated Care Boards to collect, analyse, and publish information relating to inequalities in 'people's access to, outcomes from and experience of health services'. This amendment was added to the Bill.

While this doesn't precisely follow the amendment proposed by the Health Foundation, the government's concession is very welcome and should help to support a data driven approach to narrowing health inequalities.

We are now seeking clarity about how and to what extent NHS England will be expected to exercise this new power. In particular, the amendment – and national policy and planning guidance – is focused on requiring NHS bodies to report on inequalities within localities and services. Will the DHSC or NHS England seek to compile national-level data about inequalities

between different parts of England, as well as the inequalities within them? And, if so, will Ministers commit to publishing such data to allow progress in tackling inequalities and to enable comparisons across different areas?

Amendment on the triple aim

This ‘triple aim’ duty requires NHS England, ICBs, NHS trusts and foundation trusts to ensure they consider the effects of their decisions on the health and wellbeing of the population, quality of care, and the sustainable use of NHS resources. When first introduced, the triple aim duty did not explicitly mention health inequalities.

In the House of Lords, government proposed an amendment to incorporate health inequalities into the triple aim. While this does not amend the triple aim itself, it adds new subsections making clear that (a) and (b) of the triple aim include a reference to health inequalities. We welcomed this amendment. By explicitly referencing inequalities in the triple aim duty, a clearer signal will be sent to health and care leaders about its importance as a goal, with NHSE, ICBs and Trusts required to consider the impact of their decisions on health inequalities.

Improving data sharing

Better use of data can also play an important role as the health and social care system recovers from COVID-19, but it is a long way from using data optimally.

The Bill outlines steps to clarify and improve data sharing between health and social care bodies. This should support efforts to coordinate services in ICSs. But to improve population health, data sharing will need to go beyond health and social care data and include the wide range of other services that are provided by local authorities. While the Bill would give ICBs a duty to promote research (replicating the existing duty on CCGs), there is little detail included on the use of data for research purposes and how the Bill might support this.

In social care, there are longstanding weaknesses in how data are used, collected, and shared.[12,13] A lack of data on social care has affected the pandemic response.[14] The Bill’s provision for both public and private care providers to share client-level social care data, as well as other information from and about the providers of social care, should help to address some of these structural problems in the sector. But the focus appears to be primarily on outputs (for example, data on capacity and risk) and has less information about improving data on outcomes and patient experience for social care users.

Government must be transparent on how, and by who, data will be used and should engage with the public and health and social care professionals to build and maintain trust on this topic. To be successful, policies must also go beyond what data are collected to consider how they are used to improve care – including the investment needed to boost data infrastructure, data literacy, and the effective use of data analytics.

Further reading

To read further analysis of proposals within the Bill, please visit our webpage on the Health and Care Bill or see our Briefing for the Commons Public Bill Committee.

If you have any questions on the content of this briefing, please email Caitlin Law, External Affairs Officer at the Health Foundation on caitlin.law@health.org.uk

Appendix

Amendment to address workforce shortages (29)

This amendment was added to the Bill in the House of Lords.

Page 42, leave out lines 14 to 19 and insert—

> “(1) The Secretary of State must, at least once every two years, lay a report before Parliament describing the system in place for assessing and meeting the workforce needs of the health, social care and public health services in England.
>
> (2) This report must include—
>
> (a) an independently verified assessment of health, social care and public health workforce numbers, current at the time of publication, and the projected workforce supply for the following five, ten and 20 years; and
>
> (b) an independently verified assessment of future health, social care and public health workforce numbers based on the projected health and care needs of the population for the following five, ten and 20 years, consistent with the Office for Budget Responsibility long-term fiscal projections.
>
> (3) NHS England and Health Education England must assist in the preparation of a report under this section.
>
> (4) The organisations listed in subsection (3) must consult health and care employers, providers, trade unions, Royal Colleges, universities and any other persons deemed necessary for the preparation of this report, taking full account of workforce intelligence, evidence and plans provided by local organisations and partners of integrated care boards.”

Government proposed amendments to the care act (formerly clause 155)

This clause was removed from the Bill in the House of Lords.

> “(1) The Care Act 2014 is amended as follows.
>
> (2) In section 15 (cap on care costs), for subsections (2) and (3) substitute—
>
> “(2) The reference to costs accrued in meeting the adult’s eligible needs is a reference—
>
> (a) in so far as a local authority met the eligible needs, to how much of the cost of meeting those needs at the local authority’s rate the adult was required to

pay (as reckoned from the amount that was specified in the local authority's personal budget in respect of those needs (see section 26(2)(b)));

(b) in so far as a local authority did not meet the eligible needs, to what the cost of meeting those needs would have been at the rate of the responsible local authority (as reckoned from the amount that was specified in the personal budget (see section 26(2A)(a)) or the independent personal budget (see section 28(1)) in respect of those needs).

(3) A reference in subsection (2)(b) to eligible needs does not include any eligible needs during a period when the adult had neither a personal budget nor an independent personal budget, other than eligible needs during the period between the making of a request for an independent personal budget and its preparation.

(3A) For the purposes of this Part an adult's needs are "eligible needs" if—

(a) the needs meet the eligibility criteria,
(b) (b) the needs are not being met by a carer, and
(c) (c) the adult is ordinarily resident or present in the area of a local authority.

(3B) In this Part, "the responsible local authority" means the local authority in whose area the adult is ordinarily resident or in whose area the adult is present (where the adult is of no settled residence)."

(3) In section 24 (the steps for the local authority to take), for subsection (3) substitute—

"(3) Where no local authority is going to meet any of an adult's needs for care and support, the local authority that is for the time being the responsible local authority must prepare an independent personal budget for the adult (see section 28) if—

(a) the adult has any eligible needs, and
(b) the adult has at any time asked a local authority that was, at that time, the responsible local authority, to prepare an independent personal budget."

(4) In section 26 (personal budget), for subsections (1) and (2) substitute—

"(1) A personal budget is a statement which specifies, in respect of the adult's needs which a local authority is required or decides to meet as mentioned in section 24(1)—

(a) the cost of meeting those needs at that local authority's rate,
(b) (b) how much of that cost the adult must pay, on the basis of the financial assessment, and
(c) (c) the amount which that local authority must pay towards that cost (which is the balance of the cost referred to in paragraph (a)).

(2) If the needs referred to in section 26(1) include eligible needs, the personal budget must also specify—

(a) the cost of meeting those eligible needs at that local authority's rate,
(b) (b) how much of that cost the adult must pay, on the basis of the financial assessment, and
(c) (c) where the amount referred to in paragraph (a) includes daily living costs, the amount attributable to those daily living costs.

(2A) If the adult also has eligible needs which are not being met by any local authority, the personal budget must specify—

(a) what the cost of meeting those eligible needs would be at the responsible local authority's rate, and
(b) (b) where the amount referred to in paragraph (a) includes daily living costs, the amount attributable to those daily living costs.

(2B) References in this section to the cost of meeting needs at a local authority's rate are to the cost that the local authority would incur in meeting those needs, assuming for the purposes of this subsection that the adult is not paying any amount in respect of those needs and has not expressed any preference for particular accommodation."

(5) In section 28 (independent personal budget)—

(a) for subsection (1) substitute—
"(1) An independent personal budget is a statement which specifies what the cost of meeting the adult's eligible needs would be at the responsible local authority's rate (but the independent personal budget need not specify the cost of meeting those needs at any time when the local authority required to prepare it has ceased to be the responsible local authority).";
(b) after subsection (2) insert—
"(2A) References in this section to the cost of meeting needs at a local authority's rate are to the cost the local authority would incur in meeting those needs, assuming for the purposes of this subsection that the adult is not paying any amount in respect of those needs.";
(c) omit subsection (3).

(6) In section 29 (care account), in subsection (1), in the words before paragraph (a), for the words from "the local authority" to "present" substitute "the responsible local authority".

(7) In section 31 (adults with capacity to request direct payments), in subsection (1)(a), for "needs to which the personal budget relates" substitute "adult's needs which a local authority is required or decides to meet as mentioned in section 24(1) (see section 26(1)(c))."

(8) In section 32 (adults without capacity to request direct payments), in subsection (1)(a) for "needs to which the personal budget relates" substitute "adult's needs which a local authority is required or decides to meet as mentioned in section 24(1)(see section 26(1)(c))."

(9) In section 37 (notification, assessment etc.), in subsection (15), omit paragraph (a).

(10) In section 80 (Part 1: interpretation), in the table in subsection (1), at the appropriate places insert—

"Eligible needs	Section 15(3A)"
"The responsible local authority	Section 15 (3B)"

Amendments to strengthen reporting on health inequalities

Government amendment (10)

This amendment was added to the Bill in the House of Lords.

After clause 6 insert the following new Clause—

"Information about inequalities

(1) The National Health Service Act 2006 is amended as follows.

(2) After section 13S insert—

"13SA Information about inequalities

(1) NHS England must publish a statement setting out—

(a) a description of the powers available to relevant NHS bodies to collect, analyse and publish information relating to—

(i) inequalities between persons with respect to their ability to access health services; (ii) inequalities between persons with respect to the outcomes achieved for them by the provision of health services (including the outcomes described in section 13E(3)); and

(b) the views of NHS England about how those powers should be exercised in connection with such information.

The Health Foundation original amendment

Clause 3, page 2, line 19, at end insert—

"(3A) In section 13G (duty as to reducing inequalities), after "the provision of health services." insert—

"(2) NHS England must publish guidance about the collection, analysis, reporting and publication of performance data by relevant NHS bodies with respect to factors or indicators relevant to health inequalities.

(3) Relevant NHS bodies must have regard to guidance published by NHS England under this section.

(4) In this section "relevant NHS bodies" means—

(a) NHS England,

(b) integrated care boards,

(c) integrated care partnerships established under section 116ZA of the Local Government and Public Involvement in Health Act 2007

(d) NHS trusts established under section 25, and

(e) NHS foundation trusts.""

[1] Helen Whately, House of Commons written answer, 23 July 2020 (UIN 71059). https://questions-statements.parliament.uk/written-questions/detail/2020-07-08/71059.
[2] Imison C, Sonola L, Honeyman M, Ross S. The reconfiguration of clinical services: what is the evidence? King 's Fund, 2014.
[3] Fulop NJ, Ramsay AIG, Hunter RM, et al. Evaluation of reconfigurations of acute stroke services in different regions of England and lessons for implementation: a mixed-methods study. Health Services and Delivery Research 2019;7.
[4] Timmins N. Glaziers and window breakers: former health secretaries in their own words Health Foundation. 2020. https://www.health.org.uk/publications/reports/glaziers-and-window-breakers.
[5] Baxter S, Johnson M, Chambers D, Sutton A, Goyder E, Booth A. The effects of integrated care: a systematic review of UK and international evidence. BMC Health Serv Res. 2018;18:350.
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[8] Perkins N, Smith K, Hunter DJ, Bambra C, Joyce K. 'What counts is what works'? New Labour and partnerships in public health. Polit Policy. 2010;38:101-17.
[9] Mackie S, Darvill A. Factors enabling implementation of integrated health and social care: a systematic review. Br J Community Nurs. 2016;21:82-7.
[10] Fulop N, Protopsaltis G, Hutchings A, et al. Process and impact of mergers of NHS trusts: multicentre case study and management cost analysis. BMJ. 2002;325:246.
[11] Suleman et al., The Health Foundation, *Unequal pandemic, fairer recovery: The COVID-19 impact inquiry report*, July 2021 (https://health.org.uk/publications/reports/unequal-pandemic-fairer-recovery).
[12] Office for Statistics Regulation. Adult social care statistics in England. OSR. 2020. https://osr.statisticsauthority.gov.uk/publication/report-on-adult-social-care-statistics-in-england/.
[13] Hanratty B, Burton JK, Goodman C, Gordon AL, Spilsbury K. Covid-19 and lack of linked datasets for care homes. BMJ. 2020; 369: m2463.
[14] Dunn P, Allen L, Alarilla A, Grimm F, Humphries R, Alderwick H. Adult social care and COVID-19 after the first wave: assessing the policy response in England. London: Health Foundation. 2021. https://www.health.org.uk/publications/reports/adult-social-care-and-covid-19-after-the-first-wave.