Health and Care Bill 2021-22

Key points and questions for the second reading, 14 July 2021

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13 July 2021

The Health and Care Bill which was introduced in the House of Commons on 6 July 2021 is a major reorganisation of the NHS in England which will complete the dismantling of it as a universal, comprehensive, publicly funded and provided service free at the point of delivery.

It is an astonishing attempt to allow the Secretary of State, an enlarged NHS England as 'rule-maker and regulator', and new public-private 'Integrated Care Boards' (ICBs), to reduce services, limit expenditure, further degrade local accountability and entrench the market.

Key points - summary

If Parliament enacts this Bill:

(1) there will no longer be a statutory duty on any body to arrange provision of secondary (i.e., hospital) medical services – only a power for ICBs to do so;

(2) ICBs will only have a "core responsibility" for a "group of people" in accordance with enrolment rules made by NHS England, evoking the US definition of a health maintenance organisation which provides "basic and supplemental health services to its members";

(3) it will be possible for ICBs to award and extend contracts for health care services of unlimited value without advertising, including to private companies;

(4) private health companies will be able to be members of ICBs, their committees and sub-committees, which will plan NHS services and decide how to spend NHS money;

(5) NHS England will have new powers to impose limits on expenditure by NHS trusts and NHS foundation trusts;

(6) integrated care partnerships will be set up as joint committees of local authorities and ICBs to draw up integrated care strategies, with no restrictions on membership and without clear transparency obligations;

(7) payments will be determined by NHS England after consultation with providers, including private providers, and can distinguish between different types of providers, different groups of patients and different types of services;

(8) local authority representation on ICBs will be limited to one member covering (usually) several local authorities, whilst the more local 'place-based' ICB committees will not have power to determine their budgets;

(9) local authority powers to refer reconfigurations will be affected because the Secretary of State is to be given new intervention powers, but exactly how is unclear.

The Bill does nothing to:

- rebuild and restore local, primary medical services, community, mental health and hospital services (e.g., staffing and beds) which the covid-19 pandemic has exposed as being seriously inadequate after years of service closures and cuts;
- address the failings of the centralised communicable disease control system, and wider public health system, revealed during the covid-19 pandemic;
- address the broken social care system with which health services are supposed to be integrated;
- prevent corporate take-overs of GP services.

Questions

Why has the duty to arrange (secondary) medical services been removed?

Why has the duty to arrange ophthalmic services been removed?

Will ICBs be named NHS ICBs?

Why is there no requirement for the name of ICBs to meet prescribed requirements?

Why should ICB constitutions not be required to specify its members (like CCG constitutions)?

Why should private companies be allowed to be part of an ICB and so be part of making decisions about how public money will be spent?

Why has the concept of 'core responsibility' been introduced and what does it mean?

Will an ICB be responsible for arranging accident and emergency services, and ambulance services, for every person present in the ICB area (as CCGs are)?

Why will there be enrolment rules, and why is NHSE in control of them and not Parliament?

What factors will determine NHS England's rules for the services that are not to be paid for by the NHS and for deciding who is eligible for the services which are to be paid for by the NHS?

How will groups of people be defined and allocated to ICBs?

What is the purpose of having non-overlapping areas for ICBs if they do not serve all residents in the area?

Can residents living in one ICB area belong to a different ICB?

How will local authorities be involved if not all of their residents are in the groups of people served by their ICB? Will local authorities have to be members of multiple ICBs?

Can an ICB commission services on behalf of another ICB and if so how will groups of people be consulted?

To what extent will patients and residents have a choice of ICB?

Can people change ICB and if so on what basis and how frequently?

To what extent will patients have choice of provider outside of ICB contracts when services are contracted through their ICB? What about second opinions?

What will be the basis of resource allocation to ICBs?

Will there be a single budget allocated to ICBs for all health care, i.e., primary medical health services, community services, mental health services and acute hospital care? If so, how will funding flows be monitored for each of these?

Will resource allocation be based on all residents in the geographic area or groups of people?

How will equity in funding be ensured, both to an ICB and across ICBs?

How will ICBs reconcile the different needs of individual place-based areas for services and ensure equity of resources, staffing and services?

What planning capacity will ICBs have?

How will ICBs safeguard against provider mergers and monopolies that extend across ICBs and drive decisions in respect of service planning?

Will all GP practices have to belong to an ICB?

How will funding flow to Primary Care Networks (PCNs) and to GP practices, and from PCNs to GP practices?

Why will ICPs have no specific transparency obligations?

Key points – more detail

1. There will no longer be a statutory duty on any body to arrange provision of secondary (i.e., hospital) medical services – only a power for ICBs to do so

Clause 15 - Commissioning hospital and other health services; NHS Act 2006, ss. 3 & 3A

The government had a qualified legal duty to provide hospital medical services "throughout England" from 1946 until 2012. Under the Health and Social Care Act 2012, this duty was repealed and 200+ clinical commissioning groups (CCGs) were given under s.3 of the 2006 NHS Act a duty to arrange provision of medical, and other key services and facilities, such as nursing and ambulance services, and hospital and other accommodation. The duty to arrange provision of these services and facilities will pass to 42 ICBs,[1] **but excluding medical services. The reasons for these exclusions are not explained**. If the exclusion is enacted, there will be no duty on ICBs to arrange secondary medical services with NHS Trusts or NHS foundation trusts (or private providers). An ICB could only then arrange such services by exercising their power, but not obligation, to do so under section 3A of the 2006 Act. **The duty to arrange ophthalmic services will also be removed from section 3.**

The exclusion of medical services from section 3 is particularly concerning in the light of new payment rules (see section 7 below) allowing categories of services not to be paid for. The possibility that has always existed for patients to challenge in court the non-provision of NHS services will be further reduced.

2. ICBs will only have a "core responsibility" for a "group of people" in accordance with enrolment rules made by NHS England, evoking the US definition of a health maintenance organisation which provides "basic and supplemental health services to its members"

Clause 14 - People for whom integrated care boards have responsibility, and new section 14Z31

In 2012, the duty on each CCG was to arrange provision of key services "for persons for whom it has responsibility". This term was defined in the primary legislation as persons provided with primary medical services by a CCG member and others who usually reside in the CCG's area and are not provided with such services by a CCG member. Under the Bill NHS England (NHSE) will now make enrolment rules for determining "the ***group of people*** for whom each [ICB] has ***core*** responsibility" (emphases added). This evokes the US definition of a health maintenance organisation which provides "basic and supplemental health services to its members"

[1] There are currently 42 non-statutory Integrated Care Systems, but the Bill does not stipulate the number of ICBs.

Those rules must ensure that everyone who is provided with NHS primary medical services, and everyone who is usually resident in England and is not provided with NHS primary medical services, is allocated to at least one group, subject to any exceptions made by regulations. There is no requirement of residence in the ICB area. The ICB must then arrange provision of key services for the group of people allocated to the ICB by NHSE's rules, and such other people (not persons) as may be prescribed (clause 15, inserting a new section 3 into the 2006 Act).

Why the concept of "core" responsibility has been introduced is not explained, and its meaning is unclear.

There is no provision (as there is for CCGs) aimed at ensuring that accident and emergency services, and ambulance services, must be arranged for all persons present in an ICB area.

Bizarrely, subsection (4) of new section 14Z31 proposes to give the Secretary of State a power to replace section 14Z31 with a new section which would provide that "the group of people for whom an [ICB] has core responsibility are to the people who usually reside in its area", subject to prescribed exceptions. **Why is this exceptional power to amend primary legislation needed? Why is residence in the ICB area not the starting basis for ICB responsibility?**

3. It will be possible for ICBs to award and extend contracts for health care services of unlimited value without advertising, including to private companies

Clauses 68 - Procurement regulations, and 69 - Procurement and patient choice: consequential amendments etc.

Procurement – as opposed to direct provision - is necessary because the purchaser/provider split – the need for a 'commissioner' and a 'provider' - is not being abolished. Putting one (major) commissioner and representatives of providers in a single body does not abolish the split.

The Bill will repeal section 75 of the Health and Social Care Act 2012, and revoke the NHS (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013, which required virtually compulsory advertising of contracts for health care services.

Clause 68 provides for new regulations on procurement of health care services and of goods and services procured with health care services. NHSE will be able to publish guidance about compliance with the regulations.

Repeal of section 75 is welcome. Yet transparently competing for contracts is the check against corruption and cronyism within a market model. NHSE consulted on its 'NHS Provider Selection Regime' in February 2021. It proposes a light touch regime that distinguishes between (a) continuing with existing providers, (b) selecting the most suitable provider when a service is new or changing substantially, but deeming a competitive procurement inappropriate, and (c) selecting a provider by running a competition. We

assume that the NHSE guidance, facilitated and required by the new regulations, will be largely based on these proposals.

There is every possibility that under the new regulations private companies providing services will be able to extend their contracts or even be awarded new contracts without competition.

4. Private health companies will be able to be members of ICBs, their committees and sub-committees, which will plan NHS services and decide how to spend NHS money

Clause 13 - Establishment of integrated care boards, and Schedule 2

Each ICB will be established by order made by NHSE for an area within England, which must not coincide or overlap with the area of any other ICB. Together, the whole of England must be covered. The order must set out the ICB's constitution or refer to a published document where it is set out.

The constitution must specify the name of the ICB and the area for which it is established. There is **no requirement for them to be named as "NHS Integrated Care Boards"**, and no provision (as there is in the current NHS Act for CCGs) for the ICB name to comply with prescribed requirements. One of those requirement for CCGs is that its name must begin with "NHS" in capital letters.

An ICB will consist of a chair appointed by NHSE and approved by the Secretary of State; a chief executive appointed by the chair with NHSE's approval; one member jointly nominated by (i) NHS trusts and foundation trusts, (ii) providers of primary medical services, and (iii) by the local authorities in the ICB area; and anybody else, including private companies, in accordance with the ICB's constitution and any regulations. Unlike for CCGs, **an ICB constitution will not have to specify its members.**

NHSE has stated that "All members of the [ICB] will have shared corporate accountability for delivery of the functions and duties of the ICS". If representatives of private companies are members of ICBs, sharing this accountability will conflict with the legal duties of company directors, in particular the duty to "act in the way he considers, in good faith, would be most likely to promote the success of the company for the benefit of its members as a whole."

The constitution must specify arrangements for exercising the ICB's functions, and this may include committees and sub-committees. These **committees may consist entirely of, or include, persons who are not members or employees of the ICB – such as private companies.**

According to the Explanatory Notes, an ICB "will have the ability to exercise its functions through place-based committees (while remaining accountable for them) and it will also be directly accountable for NHS spend and performance within the system." (paragraph 38).

5. NHS England will have new powers to impose limits on expenditure by NHS trusts and NHS foundation trusts

Clauses 21-24 - Integrated care system: financial controls; NHS Act 2006, new s.223C, 223GB

These clauses combine to expand NHSE's control of expenditure to NHS trusts and NHS foundation trusts. NHSE will be allowed to impose financial requirements on ICBs as regards their management or use of financial or other resources, including limits on expenditure or resource use.

6. Integrated care partnerships will be set up as joint committees of local authorities and ICBs to draw up integrated care strategies, with no restrictions on membership and without clear transparency obligations

Clause 20: Integrated care partnerships and strategies, and the Local Government and Public Involvement in Health Act 2007, ss.116, 116A and 116B

The current system for needs assessment and associated strategies is set out in ss.116, 116A and 116B of the Local Government and Public Involvement in Health Act 2007. Section 116 introduced a requirement on local authorities and Primary Care Trusts (PCTs) to undertake a joint strategic needs assessment of the health and social care needs for the authority's area (JSNA). According to the Explanatory Notes, "This will determine what will be needed in terms of the discharge of health and social care functions in relation to the area of the local authority." CCGs replaced PCTs as local authority partners in 2013, and under the Bill, ICBs will replace CCGs in preparing JSNAs with local authorities.

An "integrated care partnership" (ICP) must be set up as a joint committee by each ICB and each responsible local authority whose area coincides with or falls partly within the ICB's area (new section 116ZA). The ICP committee will have one member appointed by the ICB, one by each LA, and others appointed by the ICP. There are no requirements as to whom the ICP can appoint as members. These could and probably would include private companies, as most adult social services are provided by private companies. In the words of the White Paper which preceded the Bill, "local areas can appoint members and delegate functions to it as they think appropriate" (p.75). It will not have a constitution and will decide its own procedure.

An ICP must prepare an "integrated care strategy" setting out how the needs assessed by the JSNA "in relation to the areas of the responsible local authorities so far as those needs relate to the [ICP's] area" are to be met by the exercise of functions of the ICB, NHS England, or the local authority(ies).

The integrated care strategy then goes to the ICB(s) and the local authorities, and it is their job to prepare "a joint local health and wellbeing strategy" setting out how the needs assessed by the JSNA in relation to the responsible local authority's area are to be met by the exercise of functions of the responsible local authority, the ICB(s) or NHS England (i.e., the same bodies, as for the integrated care strategy but ordered differently in the Bill).

ICBs, local authorities and NHSE must have regard to the JSNA, the integrated care strategy and the joint local health and wellbeing strategy "so far as relevant". Needs assessments for services, including monitoring of demographic changes and service developments, were in the past undertaken by public health departments in order to inform service planning, workforce, and estate planning. These provisions are no substitute for such needs assessments, particularly as public health remains divorced from health services, and when public health specialists will have at best a limited understanding of, and no direct involvement in, the health services or the workforce that are required.

Unlike for ICBs, the Bill does not provide for ICPs to be a public authority subject to the Public Bodies (Admission to Meetings) Act 1960; and the joint committee does not appear to be a committee of a local authority to which the provisions of Part VA of the Local Government Act 1972 on access to meetings and documents of committees and sub-committees apply.

7. Payments will be determined by NHS England after consultation with providers, including private providers, and can distinguish between different types of providers, different groups of patients and different types of services

The national tariff is to be abolished and new rules will be drawn up by NHSE termed the 'NHS Payment Scheme'.

The rules will specify prices and/or formulae, and may "make different provision for different services or provision for some services but not others", and "make different provision for the same service by reference to different circumstances or areas, different descriptions of provider, or other factors relevant to the provision of the service or the arrangements for its provision". They may also "confer a discretion on the commissioner".

In order to achieve a "fair level of pay for providers", NHSE must have regard to "differences in the costs incurred in providing…services to persons of different descriptions" and also to "differences between providers with respect to the range of those services that they provide".

Before publishing the rules, NHSE must either carry out an assessment of the likely impact of the proposed scheme, or publish a statement setting out its reasons for concluding that such assessment is not needed. NHSE must also first consult with the ICBs and providers, including private providers.

If a 'prescribed percentage' of ICBs, and/or, separately, of providers, object, NHSE must then consult with representatives of the ICBs or of the providers.

NHSE will have wide discretion in deciding on the rules, including the ability to determine what services will and will not be paid for, and on who will be eligible. **The way is clear for services not to be provided and not paid for, backed by dropping the legal duty to arrange hospital services (see section 1 above), and for lobbying by representatives of private healthcare providers. Patients having to pay for services that are no longer paid for or provided by the NHS is now likely.**

8. Local authority representation on ICBs will be limited to one member covering (usually) several local authorities, whilst the more local 'place-based' ICB committees will not have power to determine their budgets

Local authority influence on ICB decisions will be limited, as there will only be one LA representative on ICBs (see section 4 above), but the vast majority of ICBs cover more than one LA area, and usually many more.

Local authorities may sit on the more local place-based committees of the ICB, but 'places' are neither defined nor even mentioned in the Bill. Their budgets will be controlled by the ICBs.

Even LA involvement in the ICPs will not feed directly through to NHS provision, as ICBs will not be bound by the JSNA nor by the integrated care strategies, only required to have regard to them "so far as relevant".

9. Local authority powers to refer reconfigurations will be affected because the Secretary of State is to be given new intervention powers, but exactly how is unclear

Clause 38 & Schedule 6; NHS Act 2006, new s.68A & Schedule 10A

An ICB or NHSE will have to notify the Secretary of State (SoS) if it proposes a change in the arrangements made by it for the provision of NHS services, where that change impacts on the manner in which a service is delivered to individuals (at the point when the service is received by users), or on the range of health services available to individuals (a "reconfiguration of NHS services").

The SoS may then call-in the proposal for his or her decision. In addition, an ICB, NHSE, NHS trust or NHS foundation trust must notify the SoS if it is are "aware of circumstances that it thinks are likely to result in a need for the reconfiguration of NHS services".

According to the Explanatory Notes, "Most service changes are delivered and implemented locally – planned reconfigurations are developed at local or regional levels by commissioners. The current system for reconfigurations works well for the majority of changes, and this will be left in place for many day-to-day transactions. The aim of this policy is to address the minority of cases which are complex, a significant cause for public concern, or where Ministers can see a critical benefit to taking a particular course of action." (paragraphs 93-94).

It is not clear, however, how this new power would affect the ability of local authorities to refer reconfigurations to the SoS under Part 4 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.