Camden Council meeting, Monday 24 January 2022 at 7pm

Request to make a deputation on the Health and Care Bill

By Peter Roderick (Camden resident, in person) and Professor Allyson Pollock (remotely)

The Health and Care Bill is currently at its Committee stage in the House of Lords, having already passed through the House of Commons.

We request to make a deputation to the Council to provide a brief outline of the implications of the Bill's structural changes for the Council and for people living in Camden. We previously made a deputation on the Bill to the Council's Health and Adult Social Care Scrutiny Committee meeting on 13 December 2021.

We set out in section A below the key points we wish to present to the Council. In section B we provide some more background detail on the structural changes, along with a summary of structures which are omitted from the Bill but which are necessary to understand its implications. We set out what we are asking the Council to do in section C.

A. Key points

1. The Bill moves health services in England closer to the US model of mixed public and private funding, and mainly private provision, with several of the same features and risks of increasing costs and widening inequalities in access to and outcomes of health care.

2. It does this by completing the detachment of funding, planning and provision of health services from local people living in local areas, replacing it with a system based on membership or enrolment of the population into 42 Integrated Care Boards (ICBs). The shift to membership mimics the US system where private insurance companies receive public funding to cover eligible individuals, not to cover the local population.

3. Each ICB will be given a single budget pot to commission most health services but will only have "core responsibility" for a "group of people" drawn from anywhere in England and allocated to it under rules prepared (not yet published) by NHS England, without parliamentary process.

4. "Core responsibility" is a new concept which evokes the US definition of a health maintenance organisation, which arranges 'basic' and 'supplemental' services for its members. Supplemental services generally have to be paid for by further insurance or user charges.

5. Private companies will be entitled to be appointed members of ICBs and their committees which will decide how the budget pot should be spent – a government amendment in the Commons may limit but will not prevent this.

6. The Bill also establishes Integrated Care Partnerships as joint committees of ICBs and local authorities to draw up an integrated care strategy. They will have little power, and should not be confused with 'place-based partnerships' which are non-statutory and have no required governance or procedures.

7. ICBs are a veneer. Real power, decision-making and influence will lie with 4 public and private groups that are not mentioned in the Bill and whose membership, governance and procedures as

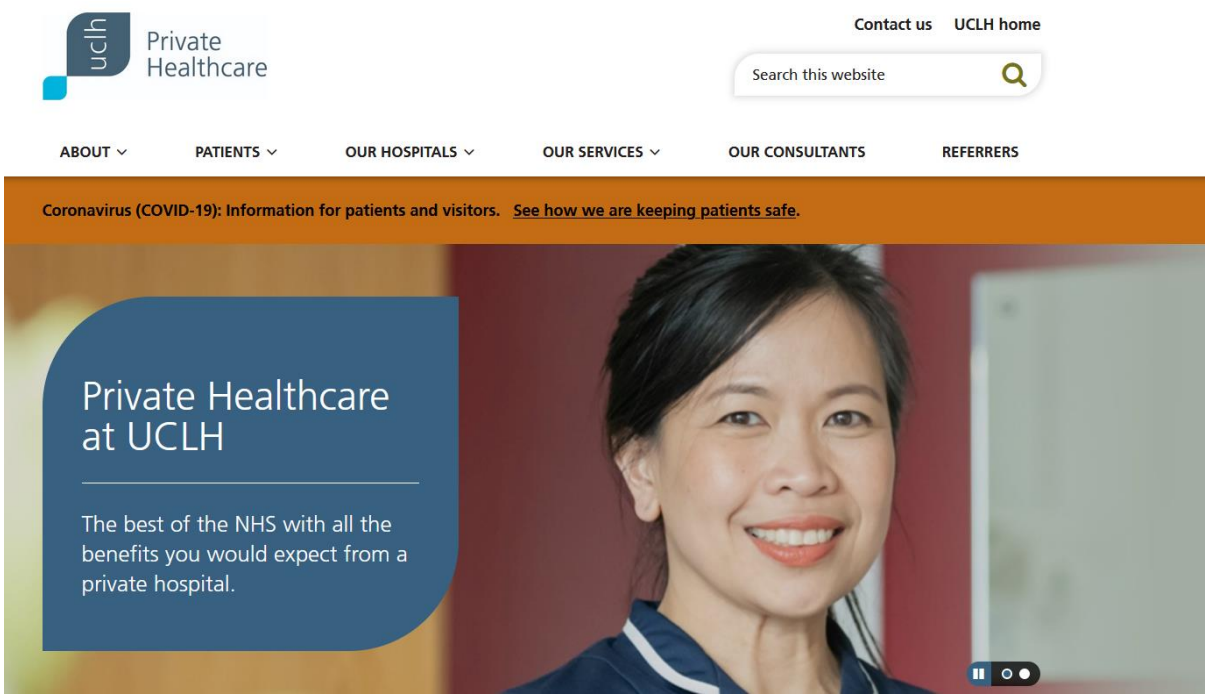
groups are not regulated. These are 'provider collaboratives', 'place-based partnerships', 'primary care networks', and companies accredited to the Health System Support Framework. These groups are already in place and working outside the statutory radar.

8. The ICBs can delegate functions and pass budgets through contracts to provider collaboratives who NHSE says will design services.

9. Commissioning contracts can include 'discretions' in relation to anything to be provided under the contracts – i.e., providers can decide what, where, and how services are to be provided. These 'discretions', and the introduction of 'core responsibility', signal that the levels and kinds of NHS services available will be reduced, and supplemental services will be provided to those who can afford to pay.

10. Provider collaboratives are another US feature, echoing the 'provider networks' of the private insurance companies. In the US government money can pass to insurers which make contracts with a limited number of providers to buy services for their plan members, known as 'provider networks'. Out-of-network providers can require extra payment or deny services.

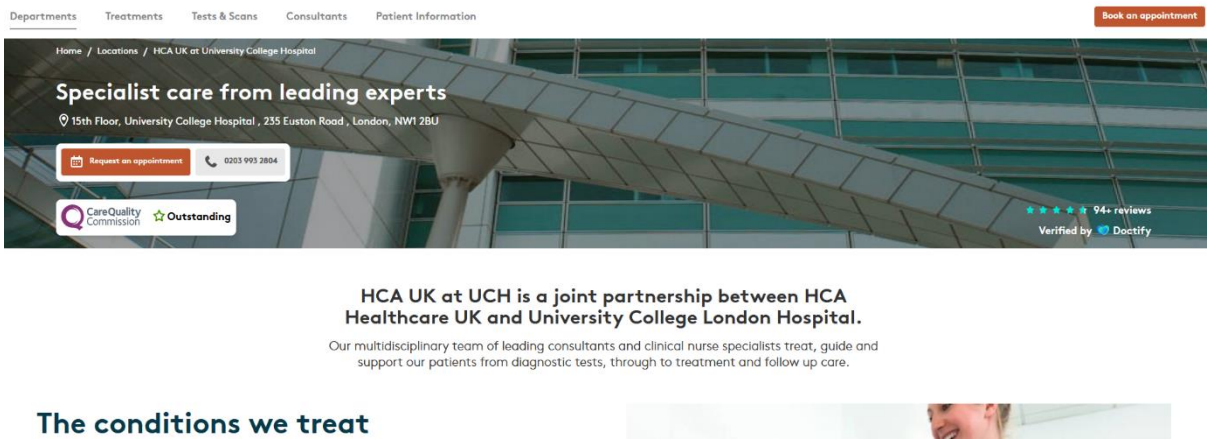
11. The blurring of the boundary between funding and provision marks a further shift to a two-tier system. Providers of NHS services can advertise private services, or requiring patients to top up basic services by paying for supplementary services. This is happening now, as NHS foundation trusts can receive 49% of their income from private patients and other non-NHS sources. Below are screenshots of the websites for UCLH's private services and for its joint venture partner, HCA Healthcare UK (Hospital Corporation of America) which describes itself as "the largest private healthcare provider in the world, and the largest provider of privately funded healthcare in the UK".



12. An ICB will not be required to arrange provision of emergency services for everybody present in its area – unlike a CCG.

13. The national tariff will be abolished, as will procurement rules for competition and commercial contracting. Market deregulation means that providers through their networks will be free to set staff pay and prices. This is currently the situation for long term care. Networks of providers are

likely to operate as cartels and use their monopoly power over prices. This will result in a major increase in health expenditure.



14. Money will increasingly leak out to shareholders and equity investors. Virgin Care has recently been taken over take over (£) by a private equity firm; The Priory Group for mental health services was sold in December 2020 to a Dutch equity group for £1.08 billion. HC-One, the UK's largest care home operator, was reported on 6 December 2021 to have moved profits offshore to private investors.

15. The Bill will require service reconfigurations to be referred to the Secretary of State instead of being dealt with locally, and a local authority's referral power will be "amended" (in ways which have not been set out).

16. Local authorities will have little influence over decisions, as ICBs will not be responsible for local populations, and include several local authorities.

B. Background detail

The NHS in England is moving to 42 Integrated Care Systems (ICSs). These are not defined in the Bill, and are only mentioned in headings or in passing. This is because they are only partly and minimally statutory. They are mainly non-statutory, with real power, decision-making and influence lying with non-statutory groups whose membership, governance and procedures as groups are not regulated.

The statutory parts are Integrated Care Boards and Integrated Care Partnerships.

The non-statutory parts are provider collaboratives, place-based partnerships, primary care networks, and companies accredited to the Health System Support Framework.

1. Allocations to ICBs and "core responsibility"

The Bill abolishes clinical commissioning groups (CCGs) and replaces them with Integrated Care Boards (ICBs).

An ICB will be responsible for commissioning most health services, but not for everybody living in its area.

Everybody receiving primary care services or who is usually resident in England must be allocated to at least one ICB under rules to be made by NHS England (NHSE) without parliamentary process. This

is the first time since 1948 that Parliament does not determine to whom NHS services must be provided.

Allocation to an ICB (North Central London in Camden's case) does not require a person to live in Camden, or in NCL. It is currently unclear to what extent people will be able to choose ICBs and to take the budget with them (as in the Babylon case); and to what extent ICBs will be able to challenge allocations and thereby in effect to select patients.

The Explanatory Notes to the Bill state: "It is expected that the basis of NHS England's general rule for ICB responsibility will continue to be in relation to GP registration to ensure operational continuity".

The people allocated to the ICB will be the "group of people" for whom the ICH has "core responsibility".

This new concept closely resembles the US definition of a health maintenance organisation (HMO). In the US, contrary to popular perception, the government funds most healthcare, much of it through private health companies such as HMOs and other "managed care organisations". These are responsible only for providing limited free services to a group of people who enrol as their "members", not a local population. They provide a core or basic package of care paid for under a health plan. Additional services are paid for through more insurance or user charges. The Committee is already aware that US private health companies already operate in Camden, such as Centene (Operose).

2. ICB membership

ICB members will consist of:

- A chair, appointed by NHSE with the approval of the Secretary of State,
- A chief executive, appointed by the chair with NHSE's approval,
- At least one[1] member nominated jointly by the NHS trusts and NHS foundation trusts that provide services in the ICB's area, approved by the chair,
- At least[1] one member nominated jointly by those providing primary medical services in the area, approved by the chair,
- At least[1] one member nominated jointly by the local authorities in the area, approved by the chair, and
- Anybody else approved by the chair.

In response to criticism that private companies could be members of ICBs, the government has introduced an amendment requiring ICB constitutions to prohibit a person becoming a member if "the appointment could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise". This will not rule out private companies sitting on the ICBs or their committees.

Unlike CCGs, ICBs will not be required to have the letters "NHS" in their name.

3. Integrated care partnerships

[1] The words "at least" were inserted by the government during the third reading in the Commons, after a similar Labour amendment (which extended to representatives of trade union and patients) had been defeated.

Each ICB and the local authorities must establish a joint committee termed an Integrated Care Partnership (ICP) with no additional minimum membership requirements or constitution. Each ICP must prepare an integrated care strategy setting out how needs identified in the joint strategic needs assessment will be met.

Four points to note. First there is a mismatch between a local authority's responsibilities for residents in its area, and ICBs (currently, CCGs), which are responsible for groups of people who may be drawn from throughout England (currently, from GP lists).

Second, public health was carved out of the NHS in 2012. Many public health functions including intelligence, data analysis, needs assessment, health service planning, and commissioning are now undertaken by commissioning support units, some of which are privatised, or outsourced to companies accredited to the Health System Support Framework, such as PWC and Optum (UnitedHealth), which in future will be operating on behalf of ICBs or provider collaboratives.

Third, the current JSNAs and health and well-being strategies for both Camden and Islington appear to be broad in their scope and largely descriptive, drawing on secondary data from Public Health England, ONS and other sources and setting high level targets. A detailed needs assessment to inform local health service planning would require surveys of local people's needs, identification of unmet need, detailed analysis of what services are provided and where locally, staffing levels, service access utilisation and gaps in service provision to meet that need. For example, mental health services have been identified as a need in the JSNAs for both boroughs. While Camden has local providers, many acute mental health services are increasingly contracted out to large FTs and private providers remote from local people, e.g., The Priory Group and Cygnet. Local residents and children and their families may have to travel hundreds of miles to access care. It is hard to see how these major gaps in local provision would be remedied through the JSNA.

Fourth even if a needs assessment for services were to be undertaken, each ICB must only have regard to the integrated care strategy, but ICPs cannot require its adoption. ICPs are unlikely to have much sway.

According to the NCL CCG website:

> "Integrated Care Partnerships will commission some local services while there will be a number of services that are commissioned at North Central London level, through the NCL Integrated Care System."

But commissioning services will not be a statutory function of an ICP. We wonder whether the website is confusing ICPs with place-based partnerships (see section 4 below). An ICP only has one central statutory function – to prepare the integrated care strategy.

4. The groups not mentioned in the Bill

ICBs are the veneer; ICPs are weak and limited. The real power, decision-making and influence will lie with four groups that already exist but are not mentioned in the bill: provider collaboratives, place-based partnerships, primary care networks, and companies accredited to the Health System Support Framework.

Provider collaboratives

Provider collaboratives are groups of public and private providers that NHS England has said will be responsible for designing services. ICBs will be able to delegate their functions to them, and devolve

the budgets to them. Their membership, legal form and governance is unregulated. Yet NHSE describes them as being "a principal engine of transformation".

As Andrew (now Lord) Lansley said in the second reading debate:

> "we have new provider collaboratives which, in fairness, is where the power in the NHS will lie. The Bill makes no provision for them in terms of transparency, openness or accountability."

This was also confirmed on 2 December by the Health Service Journal:

> "In the minds of most acute trust chiefs, it is provider collaboratives and groups, and not integrated care boards that will wield the greatest influence (although the former may act through their representation on the latter).
>
> Many believe ICSs will become tiny organisations effectively operating as a population data provider for collaboratives and "place-based partnerships", or disappear altogether."

The bill also proposes that commissioning contracts can include "discretions … in relation to anything to be provided under" the contracts. In practice this will allow providers to decide what, where and how services will be provided. So much for our so-called rights under the NHS constitution.

More than 40 collaboratives are listed on the NHS England website, including several private companies such as Cygnet, Priory and Elysium. There are echoes here again of the US. In the byzantine US healthcare system, private insurance companies sell health plans to individuals, some of whom may be eligible for public funding. The private insurance companies enter contracts with a limited number of providers to buy services for their plan members, known as "provider networks". An ICB will be able to operate similarly, with similar effects, for its group of people. The Northern Care Alliance is already reported to be doing this. In effect, this leaves the principle of a universal and comprehensive NHS in tatters.

Place-based partnerships

Place-based partnerships will also be unregulated and have no statutory functions, even though NHSE and the LGA describe them as "the foundations of integrated care systems". They should not be confused with ICPs. We assume some Councillors will know how these are developing in Camden/NCL. Decisions of whatever place-based partnership(s) Camden Council is a part of will legally be decisions of the NCL ICB.

Primary care networks

Following NHSE and BMA negotiations, 1,250 primary care networks are now in place, operating under network agreements, the contents of which are 'not within the remit of the CCG to challenge' (BMA). These are described by NHSE as "crucial to the development" of ICSs.

The website of North London Partners indicates (in a news item) that there are 30 PCNs in NCL, and 7 in Camden, but the links were not working on 8 December 2021.

Health System Support Framework

NHSE states that this framework is "a quick and easy route to access support services from innovative third party suppliers at the leading edge of health and care system reform, including advanced analytics, population health management, digital and service transformation". Over 200+

companies have been accredited to this framework, including Atos, Capita, Centene, Deloitte, Ernst & Young, McKinsey, PWC, Serco and UnitedHealth.

C. What we are asking the Council to do

We ask the Council to consider voting on a resolution to oppose the Bill. If the Council decides not to do so, or if that resolution is not passed, we ask the Council to consider voting on a resolution to support substantial amendments to the Bill, including:

(a) those tabled in the House of Lords-

(i) to restore the Secretary of State's duty to provide and secure NHS services nationally (Amendments 46, 168 and 169[2]),

(ii) to require an ICB to arrange emergency services for everybody present in its area (Amendment 51A),

(iii) to put place-based entities and provider networks on a statutory basis (Amendments 165 and 166),

(iv) to limit integrated provider contracts to NHS bodies (Amendment 21),

(v) to prevent private companies being members of ICBs and ICPs (Amendments 30 and 150),

(vi) to prevent APMS contract holders from being ICB members and to remove future use of APMS contracts (Amendments 28, 55 and 56),

(vii) to prevent fragmentation (Amendment 45), and

(b) further amendments-[3]

(i) to require the basis for allocation to appear on the face of the Bill, based on local residence, and to remove the concept of 'core' responsibility,

(ii) to ensure that an ICB has the same public involvement obligations as a CCG, namely that the arrangements which the ICB must make for involving the public in the planning of commissioning, in developing proposals and in decisions on impactful changes are described in its constitution along with a statement of the principles which it will follow in implementing those arrangements,

(iii) to ensure that an ICB's constitution must, as a CCG's constitution must, specify the members of the ICB and require its name to comply with any prescribed requirements, such as its name beginning with "NHS" in capital letters, and

(iv) to retain NHS England's duty to consult with Healthwatch England on commissioning guidance.

PR & AP, 15/1/22

[2] Amendment numbers are as per the Third Marshalled List of Amendments of 14 January 2022, available here: https://bills.parliament.uk/publications/44689/documents/1250.
[3] Details of these further amendments can be read here.