Comments on the Health and Care Bill 2021-22

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The Health and Care Bill 2021-22 was published on 6 July. On the eve of publication, Keep Our NHS Public drafted a statement on what to expect. It began "KONP calls for widespread public opposition to the Bill, and for MPs and Lords to vote against it at every opportunity". It was based on reading the White Paper issued in February, and related NHS England documents. Some points are now strengthened by the text of the Bill and its Explanatory Notes.

But first, consider the timing. On 6 July, the Mirror quoted Health Secretary Savid Javid:

> "**The astonishing response of our health and care services to the COVID-19 pandemic** [*emphasis added*] has hit fast-forward on some of the bold changes the NHS set out to deliver in its Long Term Plan and shone the spotlight on other areas that require change to achieve better care for our communities.
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> "To help meet demand, build a better health service and bust the backlog, we need to back the NHS, as it celebrates its 73rd birthday this week, and **embed lessons learned from the pandemic**.
>
> "This will support our health and care services to be more integrated and innovative so the NHS can deliver for people in the decades to come."

Two months ago, such optimism would merely assume no-one remembered that the Government was responsible for delaying lockdowns in March 2020 and before Christmas, untested discharges to spread infection into care homes, key workers dying without adequate PPE, contracts dished out to crony companies without public procurement, a privatised Test & Trace system which failed to control the virus, exhausted and demoralised healthcare staff, and 150,000 deaths.

Now, with the Delta variant spreading rapidly and the Health Secretary himself anticipating 100,000 new infections per day later this summer, public confidence in "Freedom Day" is crumbling. A plan to "embed lessons learned from the pandemic" could and should face a backlash.

A) Breaking the National NHS while controlling local system budgets
B) Boards and Partnerships open to the private sector
C) NHS Payment Scheme with local variation, open to the private sector
D) Discharge to Assess
E) Professional deregulation
F) Deregulation of Procurement
G) Reconfigurations
H) Data Sharing

A) Breaking the National NHS while controlling local system budgets
The Bill confirms that CCGs will be replaced by Integrated Care Boards (ICBs) alongside Integrated Care Partnerships (ICPs). According to the Explanatory Notes (EN-1032) "The measures in the Bill that may result in cost include, but are not limited to: • The establishment and running of Integrated Care Systems (comprising of the Integrated Care Board and the Integrated Care Partnership)..." There were 42 non-statutory Integrated Care Systems in April, but the total number of ICBs is not specified. Each ICB will be responsible for planning and financial accountability in

their local system. Each ICB will be “directly accountable for NHS spend and performance within the system” (EN 38). The spending power is under the control of NHS England, as per Clause 23 (3):
Power to impose financial requirements on integrated care boards
(1) NHS England may give integrated care boards directions about their management or use of financial or other resources.
(2) The directions that may be given include a **direction imposing limits on expenditure or resource use** by integrated care boards.

Each ICB, and its partner NHS trusts and NHS foundation trusts “must prepare a plan before the start of each relevant period to set out how it will exercise its functions over the next 5 years” (EN 334). In relation to capital expenditure “It is the role of the ICB to ensure system capital expenditure is affordable within these envelopes and to prioritise its spending plans in accordance with the system wide health needs between each of the system providers. The Bill will establish, a joint duty between the ICB and its partner Trusts and Foundation Trusts to prepare a plan setting out their use of planned capital resources.” (EN 29).

B) Boards and Partnerships open to the private sector
Both the ICB and the ICP will be open to the private sector. The ICP will bring together “health, social care, public health (and potentially representatives from the wider public space where appropriate, such as social care providers or housing providers)” (EN 40). **Social care providers are overwhelmingly private**, and the open ended description is explicit in the Bill: “The integrated care partnership for an area is to consist of— (a) one member appointed by the integrated care board, (b) one member appointed by each of the responsible local authorities, and (c) **any members appointed by the integrated care partnership. An integrated care partnership may determine its own procedure (including quorum).**” (Clause 20 (4)). The ICP is responsible for “developing a strategy to address the health, social care and public health needs of its system. The ICB and local authorities will have to have regard to that plan when making decisions” (EN 41).

The ICB, which controls the system budget under NHS England limits, will “as a minimum, include a chair, Chief Executive Officer, and representatives from NHS Trusts and NHS Foundation Trusts, general practice, and local authorities. Beyond that, local areas will have the **flexibility to determine any further representation** in their area.” (EN 39). General practice may be under private sector control, as with Operose-Centene, and the open ended description and limited local authority representation – potentially just one member – is again explicit in the Bill.

As detailed in Schedule 2, the ICB Chair will be appointed by NHS England with approval by the Secretary of State, and the Chief Executive, appointed by the Chair with approval by NHS England. Ordinary members of the ICB **will include** one member nominated jointly by the NHS trusts and foundation trusts within the ICB area, one member nominated jointly by persons who provide primary medical services within the area, and one member nominated jointly by local authorities wholly or partly within the area. The qualification for being nominated is open. It “may, in particular, be framed by reference to the nature of the services that they provide”.

There is no specified limit to the size of the ICB, as “will include” is open ended, and nothing to rule out a private-sector representative or employee being nominated on the basis of their services to primary care, for example. ICB committees with delegated powers are also wide open to the private sector. Schedule 2 (10) states:
...

(2) The arrangements may include provision—(a) for the appointment of committees or sub-committees of the integrated care board, and (b) for any such committees to consist of or include **persons other than members or employees** of the integrated care board.
(3) The arrangements may include provision for **any functions of the integrated care board to be exercised on its behalf** by—(a) any of its members or employees, (b) a committee or sub-committee of the board.

By contrast, there are no details on how the public will influence decisions of the ICB. The only reference to ICB transparency is at Schedule 2 (11) (2): "The constitution must also specify the arrangements to be made by the integrated care board for securing that there is transparency about the decisions of the board and the manner in which they are made." This does not guarantee that papers will be published in advance, or that the public will have the right to attend meetings of the ICB or its committees, or to ask questions at meetings, although the Freedom of Information Act will apply (Schedule 4 (60)).

C) NHS Payment Scheme with local variation, open to the private sector
A key aim of the Bill is to replace the national tariff system in which treatments have a price with limited variability (EN-25). In its place, the Bill introduces a **Payment Scheme allowing greater local variation which may depend on patient characteristics and geography, undermining national pay, terms and conditions. The Bill explicitly allows the private sector to influence the details.**

As Explanatory Notes (EN-27) state: "The scheme will be published by NHS England, who will consult with ICBs as the new commissioner of most NHS services, as well as relevant providers (both NHS providers and those from the **independent** or voluntary sector)." According to the NHS Dictionary, "An Independent Sector Healthcare Provider (ISHP) is a private sector healthcare company that is contracted by the NHS in the provision of healthcare or in the support of the provision of healthcare".

Details are set out in Schedule 10 of the Bill.
At 114A (3) (e), the Rules for the Payment Scheme which are set by NHS England may: "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".
At 114A (6) in setting the Rules NHS England must have regard to: "(a) differences in the costs incurred in providing those services to **persons of different descriptions**, and (b) differences between providers with respect to the **range of those services** that they provide."
At 114C (2) Before publishing the NHS payment scheme, NHS England must consult the following — (a) each integrated care board; (b) each **relevant provider**; (c) such other persons as NHS England considers appropriate.
At 114C (8) In this section "relevant provider" means—
(a) a licence holder, or (b) another person, of a prescribed description, that provides—(i) health care services for the purposes of the NHS, or (ii) services in pursuance of arrangements made by NHS England or an integrated care board by virtue of section 7A or 7B of the National Health Service Act 2006 (Secretary of State's public health functions).

Private firms can qualify under (8) (a) as licence holders include "**independent providers**" or under (b) (i) which is a **catch-all** for services provided "for the purposes of the NHS" or under (b) (ii) as such services include, for example, the Sexual Assault Referral Centres, some of which are

provided by G4S. **Thus G4S is a relevant provider and must be consulted over the payment scheme.**

Each ICB will get an annual allocation from NHS England which they must not exceed (Clause 23 (3) 223GC), and NHS England will have the power to impose limits on expenditure or resource use (223GB). The allocation from NHSE is based on the anticipated cost of the care to be delivered over the coming year, which is priced according to the Payment Scheme, which varies between ICBs depending on geography, patient characteristics, and other unspecified factors.

Since staff costs form the majority of the NHS budget, the Scheme weakens the economic basis for national agreements on wages, terms and conditions of NHS staff.

The Bill makes no reference to such agreements, and regarding the staff of the ICB itself, simply states in Schedule 2 (17):
(2) Employees of an integrated care board are to be paid such remuneration and allowances as the board may determine.
(3) Employees of an integrated care board are to be appointed on such other terms and conditions as the board may determine.
(4) An integrated care board may pay or make provision for the payment of such pensions, allowances or gratuities as it may determine to or in respect of any person who is or has been an employee of the board.

D) Discharge to Assess
As the Explanatory Notes describe, Clause 78 "revokes the procedural requirements in the Care Act 2014 which require local authorities to carry out **social care needs assessments**, in relevant circumstances, **before a patient is discharged** from hospital… This clause introduces flexibility for local areas to adopt the discharge model that best meets local needs, including an approach known in England as 'discharge to assess' " (EN-156,157)

A critique by NHS Consultant and President of the British Geriatric Society David Oliver appeared in the BMJ last September. Oliver discussed the 'eligibility to reside' criteria in NHS England guidance on the 'discharge to assess' model. "The use of such criteria gets dangerously close to systems where insurers call the shots on how long patients are "allowed" to stay in hospital… The model also pushes problems out of hospitals and on to community services and primary care (which is not receiving any of this uplift). Beyond six weeks after discharge, it will create further demand for social care in a system that is already struggling for resources and staff. And where does it take account of outcomes after leaving, such as emergency readmissions to hospital, whether patients make it back home, or their experiences of rushed or pressurised discharges? Clearing hospital beds cannot be an end in itself… The criteria ignore many other valid reasons for staying in hospital a little longer. Examples include stress or ill health among carers, severe persistent diarrhoea or vomiting or acute metabolic disturbance, and an infectious disease that could infect others in the care home or community hospital. Above all, the judgment as to who really is "medically optimised" enough to leave, and whose support arrangements at home are sufficient at that moment to give us confidence, is best made by the clinicians who are with that patient and their family daily and who know the circumstances and concerns… When things go wrong, any formal complaint or coroner's verdict, or any negligence claim, will be answered by clinicians, not NHS England officials."

E) Professional deregulation
Clause 123 is entitled “Regulation of health care and associated professions” but actually concerns deregulation. As EN-166 explains, the powers will enable: “the abolition of an individual health and care professional regulatory body where the professions concerned have been deregulated or are being regulated by another body; the removal of a profession from regulation where regulation is no longer required for the protection of the public; the delegation of previously restricted functions to other regulatory bodies through legislation”.

As the White Paper had set out, the Government believes that “over time and with changing technology the risk profile of a given profession may change and while regulation may be necessary now to protect the public, this may not be the case in the future.” The idea appears to be that a health professional using computerised algorithms and expert systems will not require regulation.

There are three glaring errors in this. All computer systems can crash, whether from power failures, viruses or undetected software bugs. Expert systems may also be deployed long before they have been properly tested, and even then will require continual reassessment. But if the healthworkers using these systems are no longer regulated, they will no longer be trained to the same standards, and may be unaware that the system is giving the wrong answer and that they should take advice or consult their manager. They may be unable to cope if the system crashes, an outcome the NHS is expected to foresee.

Secondly, deregulation will interfere with professional development by deskilling the job role. Why would the ICB budget for specialist training if the job only requires operating a computer programme? EN-168 calls this “the development of a flexible workforce that is better able to meet the challenges of delivering healthcare in the future”.

Third, reducing the number of regulators by merging regulatory functions will mean fewer staff to cover the same tasks, which will mean that oversight cannot be carried out in full.

F) Deregulation of Procurement
Under the cover of repealing Section 75 of the Health and Social Care Act 2012, the Bill provides a power to create a separate procurement regime for clinical services, “which will include removing the procurement of health care services for the purposes of the health service from scope of the Public Contracts Regulations 2015” (EN-114). Meanwhile “the procurement of non-clinical services, such as professional services or clinical consumables, will remain subject to the Public Contract Regulations 2015 rules, until these are replaced by Cabinet Office procurement reforms” (EN-116). But “The power does however provide an ability to make provision for mixed procurements in the regime, where a contract involves a mixture of health care and other services or goods, for example if a health service is being commissioned but in the interests of providing joined up care some social care services are also commissioned as part of a mixed procurement.”

Together, this means that non-clinical services can also be exempted from PCR 2015 if they are bundled with clinical services in the procurement.

Whilst the repeal of Section 75 will be presented as “ending privatisation”, the exemption from PCR 2015 actually means converting NHS procurement from a regulated to an unregulated market. In particular, PCR 2015 contains protections under which “contracting authorities may consider incorporating social, ethical and environmental aspects into specifications, contract conditions and

award criteria. In addition specific rules have been included for handling abnormally low tenders, and on the exclusion of suppliers who have violated certain social, labour and environmental laws." The labour laws are the International Labour Organisation conventions including Freedom of Assembly and the Right to Strike.

Had the options been used over the last year, some covid crony contracts might have been ruled out before they failed to deliver, as PCR 2015 also includes the option to "impose requirements ensuring that economic operators possess the necessary economic and financial capacity to perform the contract".

The Bill will remove these protections.

G) Reconfigurations

The current power of Local Authorities to refer a decision on reconfiguration (e.g. service closures) to the Secretary of State will be overtaken by a new power of the SoS to intervene at any point in the process. As EN-95 explains, "The Bill will add a new discretionary power to the NHS Act 2006 for the Secretary of State to give a direction to NHS bodies or providers requiring a reconfiguration to be referred to him instead of being dealt with locally. The Secretary of State will be able to use this call-in power at any stage of the reconfiguration process. To support this intervention power, the current Local Authority referral power, which is set out in regulations under the NHS Act 2006 will be amended to reflect the new process. This does not remove the local Health Oversight and Scrutiny Committee (HOSC) role or the requirement to involve them in reconfigurations."

This suggests that the SoS may intervene in support of a reconfiguration before the HOSC has got to grips with public objections, pre-empting a challenge to the plans.

H) Data Sharing

Clause 81 concerns an amendment on 'dissemination of information'. EN-700 explains it will mean that "NHS Digital may only share information for purposes connected with the provision of health care or adult social care or the promotion of health (It is intended that this amendment will put beyond doubt NHS Digital's power to share data in connection with health care or adult social care. This could include for example commissioning, planning, policy analysis and development, population health management, assessment of the quality of services and individuals' experiences of them, workforce planning, research for purposes which benefit or are relevant to the provision of health or adult social care and developing innovative approaches to the delivery of health and adult social care)."

These examples from the Explanatory Notes fit neatly into NHS England's Health Systems Support Framework, under which some 200 organisations, almost all of them private companies of which at least 30 are US-owned, are accredited to support the development of Integrated Care Systems. For example, Operose is the UK arm of US health insurance and data analytics giant Centene. Operose controls dozens of GP surgeries and its former CEO Samantha Jones now advises the Prime Minister. It is accredited under the HSSF for 22 topics:

Population Health Intelligence
Business and Clinical Intelligence
Research Tools

Shared or Integrated Care Records: Infrastructure
ICT infrastructure support and strategic ICT services, including Primary Care IT support and cyber security
Decision Support Tools
Integrated Care Co-ordination and management
Development of Service Change and reconfiguration proposals
Transformation project and programme management (expertise and capacity)
Organisational redesign, governance, payment and contract reform
Workforce and leadership support
Specialist Support for ICS development
Support for implementing shared decision making and self-care programmes
Support implementing Personal Health Budgets and Integrated Personal Commissioning
Digital and remote technology
Personal Health records
Patient pathway optimisation and care model design
Patient flow solutions
Provider relationship management and supply chain support
Financial and quality measurement and assurance
Provider modernisation and transformation to deliver significant transformation
Medicines optimisation

These are topics on which, as the Explanatory Notes describe, the Bill "will put beyond doubt NHS Digital's power to share data in connection with health care or adult social care". Furthermore, as EN-1032 states, "The measures in the Bill that may result in cost include… The merger of NHS England and NHS Improvement and additional activities for that body (including supporting ICSs)".

The problems identified above are so substantial, it is hard to see how any amendments would negate the underlying aims of cost cutting, deregulation, and privatisation. The right approach is widespread public and trade union opposition to the Bill, and for MPs and Lords to vote against it at every opportunity.