Health and Care Bill

Briefing for Lords Committee Stage – proposed amendments

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References to Amendment numbers are from the Marshalled List of Amendments of 7 January 2022: https://bills.parliament.uk/publications/44541/documents/1211

In this document, we urge peers to support the amendments numbered, and to table new amendments provided, below:

Support

Amendments 21, 28, 30, 46, 55, 56, 150, 165 and 166

Table

Amendments relating to allocation of people to ICBs and core responsibility (section 2 below)

An amendment to ensure that an ICB must arrange emergency services for everybody present in its area (section 3)

An amendment to ensure that ICBs have the same public involvement obligations as CCGs (section 9)

Amendments to ensure that ICB members and names are treated in the same way as CCG members and names (section 10)

An amendment to retain NHS England's duty to consult with Healthwatch England (section 11)

1. Support Amendments 46, 168 and 169 currently in the name of Baroness Bennett

Explanation

The NHS in England as a classic public health system has been slowly but steadily eroded over three decades in favour of the market paradigm.

This Bill builds on the Health and Social Care Act 2012 by developing that paradigm further, and reducing national and local accountability. It completes the detachment of funding, planning and provision of health services from local residents and local areas, and moves to a system based on membership or enrolment of the population into Integrated Care Boards (ICBs). It will move health services in England closer to the US model of mixed funding and mainly private provision, with many of the same features and risks for increasing costs and widening inequalities in access to and outcomes of health care. A two-tier health system will continue to develop.

As former Labour MP, David Lock QC said in 2019: "The big picture is that you have a market system. If you do not want a market system and you want to run a public service, you need a different form of legal structure."

We submit that the NHS in England should be run as a public system, as it is in the rest of the UK and used to be in England.

The foundation for a public system was removed by the 2012 Act. It had already been weakened by section 1 of the 2006 NHS Act, and should be reinstated, as it was in the NHS Act 1977. This would bring the founding provision for the NHS in England, in line with the founding provision in Scotland, in Wales and in Northern Ireland.

These amendments – in almost identical form to those tabled by Labour MPs at the Public Bill Committee stage in the Commons – would reinstate sections 1 and 3 of the NHS Act 2006 as they were before the 2012 Act.

2. Table amendments relating to allocation of people to ICBs and core responsibility

Clause 15 (People for whom integrated care boards have responsibility), inserting new section 14Z31 into the NHS Act 2006

Option 1

Table an amendment 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

Page 12, leave out lines 21-29 and substitute—

> "(1) References in this Act to the group of people for whom an integrated care board has responsibility are to the people who usually reside in its area.
>
> (2) Regulations may create exceptions to subsection (1) in relation to people of a prescribed description."

Option 2

Table an amendment to require the basis for allocation to be made by regulations, and to remove the concept of 'core' responsibility

Page 12, leave out lines 21-23 and substitute—

> "(1) The Secretary of State must make regulations for determining the group of people for whom each integrated care board has responsibility."

Option 3

Table amendments to require NHS England's rules for allocation to be subject to Parliamentary process, and to remove the concept of 'core' responsibility

Page 12, line 22, leave out "core"

Page 12, line 29, at end insert—

> "(2A) The rules shall not come into effect until they have been approved by an affirmative vote of both Houses of Parliament."

Explanation

Three issues are engaged by Clause 15.

In the 2012 Act, Parliament decided to require each clinical commissioning group (CCG) to have responsibility for patients on the lists of those GP practices which are members of the CCG. Such patients could be (and have been) added to or subtracted from by regulations.

Clause 15 of the Bill, which inserts a new section 14Z31 into the NHS Act 2006, completes the switch in the administrative basis of the NHS from residency to membership, begun under the 2012 Act, and severs the link between local residents and our local health bodies. From April 2022, 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 NHSE without parliamentary process. Allocation to an ICB does not require local residence. It is currently unclear to what extent people will be able to choose ICBs, and to what extent ICBs will be able to challenge allocations and thereby in effect to select patients.

As seen in the Babylon GP at Hand case, patients can change CCG and take the budget with them. If people are able to choose an ICB, this opens up the possibility of ICBs competing for patients and promoting membership-based health plans, especially for those with lower medical risk.

Moreover, an ICB will only have "core responsibility" for the "group of people" who are allocated to it, and for those, if any, added by regulations. This evokes the definition of HMOs in US legislation as organizations providing "basic" and "supplemental" services to their members under health plans. These plans generally provide basic services, with supplemental services paid for by individuals via further insurance or out of pocket payments.[1] [2] [3] MPs during the committee stage did not mention or question this new concept of "core responsibility".

New section 14Z31(4) also gives the Secretary of State a highly unusual power to make regulations to substitute the section with an entirely new section 14Z31 which would provide that an ICB was to have core responsibility to the people who usually reside in its area. This was the basis for the NHS from 1948 until 2012. We submit it should be the basis for the NHS now, and it should appear on the face of the Bill – i.e., it should be the decision of Parliament.

We have therefore suggested 3 alternative options for amendments to Clause 15.

Option 1 puts the basis for responsibility on the face of the Bill and makes section 14Z31 read as it would read if the Secretary of State exercised his or her power in section 14Z31(4) – i.e., it restores the residency basis for NHS responsibility – and, in addition, drops the new concept of 'core' responsibility.

Option 2 would not go as far as Option 1, in that it would not determine the basis for responsibility, but would require the basis to be set out in regulations made by the Secretary of State which should be subject to the affirmative procedure.

Option 3 is weaker still. It would simply require NHS England's rules for allocation to be subject to an affirmative vote of both Houses of Parliament.

[1] Jacobson G, Rae M, Neuman T, Orgera K, Boccuti C. Medicare Advantage: How Robust Are Plans' Physician Networks? https://www.kff.org/medicare/report/medicare-advantage-how-robust-are-plans-physician-networks/. 5 October 2017.

[2] Graves JA. Nshuti L. Everson J. et al. Breadth and Exclusivity of Hospital and Physician Networks in US Insurance Markets. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2774285 JAMA Netw Open. 2020;3(12):e2029419. doi:10.1001/jamanetworkopen.2020.29419. 17 December 2020.

[3] Meyers DJ. Rahman M. Trivedi AN. Narrow Primary Care Networks in Medicare Advantage https://pubmed.ncbi.nlm.nih.gov/33469747/. J Gen Intern Med. 2021 Jan 19. doi: 10.1007/s11606-020-06534-2. Online ahead of print.

3. Table an amendment to ensure that an ICB must arrange emergency services for everybody present in its area

Clause 16 (Commissioning hospital and other health services), substituting a new section 3 of the NHS Act 2006

Page 14, line 10, at end insert—

> "(2A) The power conferred by subsection (2)(b) must be exercised so as to provide that, in relation to the provision of services or facilities for emergency care, an integrated care board has responsibility for every person present in its area."

Explanation

One of the inevitable consequences of the shift in 2012 from area- to membership-based responsibility would have been that a CCG only had to commission emergency services for its members (i.e., those on its GP lists), not for everybody present in the CCG's area. After 'the pause' in the parliamentary progress of that legislation, the government brought forward an amendment to ensure that a CCG arranged emergency services "for every person present in its area". That amendment became section 3(1C) of the NHS Act 2006. Clause 15 of the Health and Care Bill gets rid of section 3(1C) and so it will not be passed on to ICBs. This amendment is intended to prevent that happening.

4. Support amendment 165 tabled by Lord Hunt, Baroness Tyler and Baroness Thornton, and amendment 166 tabled by Lord Hunt, Baroness Thornton, Baroness Walmsley and Baroness Bennett to put place-based entities and provider networks, respectively, on a statutory basis

Explanation

Integrated Care Systems (ICSs) 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 ICBs and Integrated Care Partnerships (ICPs). The non-statutory parts are place-based partnerships, provider collaboratives or networks, primary care networks, and companies accredited to the Health System Support Framework.

These amendments would put the first two of these non-statutory groupings on a statutory basis.

Without amendment 165, place-based entities will 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.

Provider collaboratives or networks 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. This again feeds into the new notion of core responsibility and the distinction between basic and supplementary services, and the wide flexibility that providers will have.

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, and our so-called rights under the NHS constitution, in tatters.

5. Support amendment 21 tabled by Lord Davies to limit integrated provider contracts to NHS bodies

Explanation

According to NHS England, an integrated care provider contract – previously described as an accountable care organisation contract – "is one of the available options for systems to enable joined up decision making and integration of services. It will enable commissioners to award a single contract to a provider that is responsible for the integrated provision of general practice, wider NHS and potentially local authority services".

In 2019, the House of Commons Health Select Committee "strongly recommend[ed] that legislation should rule out the option of non-statutory providers holding an [Integrated Care Provider] ICP contract [in order to] allay fears that ICP contracts provide a vehicle for extending the scope of privatisation in the English NHS".[4] The model ICP contract 2019/20 provides for gain/loss agreements between commissioners and providers,[5] thereby incentivising cost reduction.

The Bill fails to implement the strong recommendation of the Health Select Committee, which was not discussed during the Public Bill Committee stage in the Commons. Amendment 21 would rectify that omission.

[4] House of Commons Health and Social Care Committee. NHS Long-term Plan: legislative proposals. Fifteenth Report of Session 2017–19. Report, together with formal minutes relating to the report. Ordered by the House of Commons to be printed 18 June 2019, paragraph 79. https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/2000/200008.htm#_idTextAnchor031

[5] NHS England and NHS Improvement. Explanatory notes to the ICP Contract. August 2019. https://www.england.nhs.uk/wp-content/uploads/2019/08/4-ICP-Contract-Explanatory-Note.pdf

6. Support amendments 30 and 150 tabled by Lord Davies to prevent private companies being members of ICBs and ICPs, respectively

Explanation

When the Bill was introduced in the Commons, there was no provision limiting the identity of members of ICBs.

Following concerns that this allowed representatives of private companies to be ICB members, the government brought forward an amendment which is now in Schedule2 (page 136): "The constitution must prohibit a person from appointing someone as a member ("the candidate") if they consider that 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".

That provision, however, falls short of preventing the private sector being on ICBs. Rather, it renders the matter one of interpretation in any given case; and it is questionable if the appointment of a private sector representative to one ICB can ever undermine the independence of the health service as a whole. Neither does the provision extend to ICB committees and sub-committees, nor to ICPs.

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."

It also conflicts with the first of the seven Principles of Public Life (the Nolan principles), namely 'selflessness':

> "Holders of public office should act solely in terms of the public interest."

Amendment 30 on ICBs is clearer than the government's weasel-worded amendment, but it still does not extend to ICB committees and sub-committees. We submit therefore that Amendment 30 should be strengthened to extend to ICB committees and sub-committees.

7. Support amendment 28 tabled by Baroness Thornton, Baroness Walmsley, Baroness Bakewell and Baroness Bennett, amendment 55 tabled by baroness Thornton and Baroness Bennett, and amendment 56 tabled by Baroness Thornton to prevent APMS contract holders from being ICB members and to remove future use of APMS contracts

Explanation

When the NHS was set up under the NHS Act 1946, arrangements were made with medical practitioners to provide personal medical services to people in the local area. These services were described as 'general medical services' (GMS). Following national negotiations, 'terms of service' were set out in regulations and incorporated into the arrangements. There was no contract in the legal sense of a tradeable asset which could be passed on to others, for example through assignment or sub-contracting; and the word 'contract' did not appear anywhere in the primary or secondary legislation.

One of the final statutes enacted under the Major government was the NHS (Primary Care) Act 1997. It introduced 'pilot schemes' for more locally flexible 'personal medical services (PMS) agreements'. These could be made between a health authority (in England and Wales) and a number of eligible persons, including GPs and NHS trusts, but also companies limited by shares where the shares were held by a trust or GPs.

In 2003 the Health and Social Care (Community Health and Standards) Act introduced contracts. As well as having the duty to provide or secure provision of primary medical services within their area, and a power to provide such services directly, Primary Care Trusts were also given the power to make arrangements for their provision, and in particular to make contractual arrangements with any person. This included arrangements with companies limited by shares. No restriction on share ownership was stipulated in the legislation. Alternative Provider Medical Services (APMS) contracts were devised in the exercise of this power, following directions from the Secretary of State, not regulations which need to be laid before Parliament.

The power to enter into APMS contracts passed to NHSE in 2012, and the Bill will now pass this power to ICBs.

APMS contracts have been described by a health industry lawyer as "the private sector's gateway to providing primary health care to NHS patients". This is because when Parliament created the two main GP contract types - General Medical Services (GMS) contracts, and Personal Medical Services (PMS) agreements – it ensured that the private sector was not eligible to hold them. It allowed companies limited by shares to hold these two types, but imposed restrictions on the identity of their shareholders. In summary, only companies with GPs, regulated health professionals and (for PMS agreements) NHS trusts and foundation trusts, as shareholders can hold them.

Major companies awarded APMS contracts are reported to have failed: e.g., UnitedHealth for the Camden Road surgery in London in 2008, which no longer exists; Atos pulled out of St Paul's Way medical centre in Bow in 2011; Serco pulled out of its out-of-hours contract in Cornwall in 2013, after a damning Select Committee report; and The Practice Group, a majority-owned Centene company, pulled out of the Osler House surgery in Harlow, Essex in 2018, according to the Daily Mail.

Most recently, in early 2021, at least 34 APMS contracts across London were in effect transferred to Operose Health Limited, a subsidiary of the giant US health company, Centene Corporation. This was achieved by the company which held the contracts, AT Medics Limited, transferring the ownership of its holding entity, AT Medics Holdings LLP, to Centene subsidiaries.

According to NHS Digital, there were 180 APMS practices in England in 2019-20, covering just over 1 million (and 1.8% of) registered patients. These can be seen on this map compiled by Dr Paul O'Brien.

Parliament should take back control of who is eligible, directly and indirectly, to hold contracts for primary medical services and rule out further use of APMS contracts.

8. Support amendment 45 tabled by Lord Davies to prevent fragmentation

Explanation

If an ICB only has (core) responsibility for those allocated to it, this allows for an ICB and its providers to hide behind this technicality when someone needs treatment but has not been allocated to that ICB. The Northern Care Alliance is already reported to be doing this. Patients should be able to access the NHS at any time anywhere in the country and dividing the NHS up into 42 ICBs and ICSs risks preventing that from being possible. Amendment 45 would remove that risk.

9. Table an amendment to ensure that ICBs have the same public involvement obligations as CCGs

Clause 20 (General functions) and new section 14Z44 (Public involvement and consultation by integrated care boards)

Page 19, line 15, at end insert—

"(2A) The integrated care board must include in its constitution—

(a) a description of the arrangements made by it under subsection (2), and

(b) a statement of the principles which it will follow in implementing those arrangements."

Explanation

At present, Schedule 4, paragraph 3 of the Bill adds ICBs to the list of bodies to which the Public Bodies (Admission to Meetings) Act 1960 applies. This list currently includes other bodies such as NHSE, NHS Digital, the CQC and NICE.

There is an obligation under this Act for meetings to be open to the public, though the body can by resolution say otherwise "whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings". One such 'special reason' may be where there will be or has been lobbying for private interests - i.e., where there is a "need to receive or consider recommendations or advice from sources other than members, committees or sub-committees of the body".

The press are entitled to ask for and be provided with copies of the agenda (but not members of the public), and may, but do not have to be given, copies of reports and other documents.

The Act only applies to committees if they "consist of or include all members of the body", which will presumably mean that ICB committees and sub-committees will not be covered.

CCGs are not subject to the 1960 Act. Under section 14Z2(2) of the NHS Act 2006, CCGs have a duty to make arrangements for involving the public in planning of commissioning, in developing proposals and in decisions on impactful changes. This provision will also apply to ICBs under new section 14Z44(2) (inserted by Clause 20).

CCGs also have additional obligations, namely to describe in its constitution the arrangements it has made under s.14Z2(2) and to include a statement of the principles which it will follow in implementing those arrangements. The Bill does not pass on these obligations to ICBs. This amendment would ensure that ICBs also have those obligations.

10. Table amendments to ensure that ICB members and names are treated in the same way as CCG members and names

Clause 14 (Establishment of ICBs) and Schedule 2 (ICBs: Constitution etc.), inserting a new Schedule 1B into the NHS Act 2006, Part 1 (Constitution of ICBs)

Page 136, line 17, delete "and", and at end insert—

"(aa) the members of the board, and"

Page 136, line 18, at end insert—

"2A. The name of the integrated care board must comply with such requirements as may be prescribed."

Explanation

A CCG's constitution must specify its name, its members and its area, and its name must comply with such requirements as may be prescribed (NHS Act 2006, Schedule 1A, paragraph 2).

A prescribed requirement - under the NHS (CCGs) Regulations 2012 – is that the name of a CCG must begin with "NHS" in capital letters.

By comparison, the Bill only requires an ICB constitution to specify its name and its area. There is no requirement for its members to be specified in the constitution, nor for its name to comply with any prescribed requirements.

These amendments would apply the same provisions in these respects to ICBs as they apply to CCGs.

11. Table an amendment to retain NHS England's duty to consult with Healthwatch England

Clause 20 (General functions) and new section 14Z49 (Guidance by NHS England)

Page 21, line 5, at end insert—

"(3) NHS England must consult the Healthwatch England committee of the Care Quality Commission—

(a) before it first publishes guidance under this section, and

(b) before it publishes any revised guidance containing changes that are, in the opinion of the Board, significant."

Explanation

The new section 14Z49 omits the duty currently on NHS England (under section 14Z8(3) of the 2006 Act) before publishing, and significantly revising, commissioning guidance for CCGs, to consult with Healthwatch England. This duty should also apply to guidance for ICBs.

We also submit that ICBs should to be named as "NHS ICBs", their constitutions should specify their members, private companies should not be permitted to be members of ICBs or to sit on their committees or sub-committees, conflicts of interests should be prevented from arising and a register of conflicts of interest should be proactively published.