Londonwide LMCs
The professional voice of London general practice

July 2021

LONDONWIDE LMCs SUMMARY BRIEFING: Health and Care Bill 2021
Innovation: working together to improve health and social care for all.
Full draft text of the Bill.

TIMING
The Health and Care Bill received its first reading on 6 July 2021.
Measures enabled by the Bill are scheduled for implementation by April 2022.

NEXT STEPS
The Bill received its **Second Reading** on **Wednesday 14 July**.
It will be followed by **Committee Stage** – the stage at which amendments will begin to be brought to the Bill – once the House returns **after summer recess in September**. It will progress through the House of Commons and House of Lords over the coming months. Dates for future stages and details of amendments tabled will be available here in due course.

Following representations from Londonwide LMCs on behalf of London general practice, we have worked with DHSC officials to expand on concerns and have been advised that as the Bill is taken through Parliament, we will be contacted with more information on the Bill including links to fact sheets on policy areas, and opportunities to comment further.

SUMMARY
This is the first major health legislation since the Health and Social Care Act 2012.
The Bill was heralded by consultations in late 2020 regarding ICS, and in early 2021 concerning provider selection.

An overarching point throughout the Bill and explanatory notes is the conflation of effectiveness, safety and patient experience under the label of "quality".

Londonwide LMCs has significant concern that not giving prominence to safety in any assessment of clinical service provision or service structure is unacceptable. You can read more in our response to previous Government consultation on ICS structures, linked from the further information section below.

Key measures covered by the Bill include:

1. **NHS structures**

- Establishing Integrated Care Systems in statute, with the possibility of creating new NHS Trusts.
- Formally abolishing any remaining CCGs at a point to be determined by the Health Secretary, with their staff, resources, and functions via-d to ICS.
- Defining the structure and responsibilities of Integrated Care Boards and Integrated Care Partnerships, and requiring ICS to establish them.
- Formally merging NHS England and NHS Improvement.
- Establishing the Health Service Safety Investigations Body in statute to investigation safety incidents in a "no blame" manner.

- **Integrated Care Systems (ICS)**

The Bill will establish ICSs in statute as bodies with formal status, powers and accountabilities – particularly regarding commissioning and managing NHS funding. Every area of England will be covered by an ICS made up of two elements – an ICB (Integrated Care Board) and an ICP (Integrated Care Partnership).

- **Integrated Care Boards (ICB)**

Responsible for commissioning and providing NHS services, and allocating and distributing funding in a specified geographic area. Largely coterminous with CCGs. They will publish a five year plan, which must be updated annually, and will develop a constitution, governance structure and membership, subject to approval from NHS England and in line with wider guidance. Minimum membership of the ICB is set out in the Bill:

- a Chair (appointed by NHS England and approved by the Secretary of State)
- a Chief Executive (appointed by the Chair and approved by NHS England)
- at least three other members, including:
  - one nominated jointly by NHS Trusts and Foundation Trusts (trusts)
  - one nominated jointly by GPs and primary care
  - one nominated by local authorities.

- **Integrated Care Partnerships (ICP)**

A joint committee formed by the ICB with all local authorities within its footprint (including any partials), these partnerships will be developed locally and in response to local need, with little national direction or intervention. They will involve a wide group of partners and will work collaboratively on public health, social care, and the wider determinants of health. ICP strategy must be considered by ICBs during their own decisions and plans. Minimum membership of the ICP as set out in the Bill is:

- at least one member appointed by the ICB
- at least one member appointed by each local authority covering the ICP
- all other members will be appointed by the ICP itself.

- **LMCs (Local Medical Committees)**

Cited within the Bill, with confirmation that ICBs will be able to recognise multiple LMCs within their given footprint – if appropriate. (SCHEDULE 3, Part 1;13).

- **Provider Collaboratives/ Place-Based Partnerships**

ICBs will control NHS funding flows within their footprints, including capital funding. They will also be able to delegate certain functions, including to Provider Collaboratives, Place-Based Partnerships (ie ICS "place"), and other partners.

- **Clinical Commissioning Groups**

Those remaining will be abolished and their duties, resources and functions will be carried over into the relevant ICB as well as any contracts they presently hold, including GP practice contracts where relevant.

Londonwide view:

- There is an absence of clinical leadership throughout ICS proposals. ICSs – as well as ICBs and ICPs – must have strong clinical leadership, representation, and engagement embedded throughout their structures. Clinical leadership (including GPs) in ICSs needs to clearly and centrality place the role of general practice professionals at the heart of decision making, recognising the value and in-statute role of LMCs covered by the ICS area (Local Medical Committees).
- Clarity and reassurance are needed on the potential for corporate private providers to sit on ICBs (the Bill neither rules in nor out). Corporate private providers should have no place on ICBs or ICPs, to prevent conflicts of interest and any undue influence over the use of vital NHS and public resources.
- We also have concerns over the transfer of commissioning responsibilities from NHSE to ICS bodies. As part of the planned comprehensive primary care commissioning transformation programme, it is critical that general practice and GPs are fully engaged and consulted to ensure the safe and effective transfer of any primary care commissioning functions. We also expect LMCs to maintain a key role in agreeing and managing contracts and supporting practices as they adapt to the new landscape.

2. **Collaboration**

- Enabling ICSs to establish joint committees with NHS bodies and providers.
- Removal of duties to promote autonomy of individual NHS bodies, with a wider focus on collaboration between local authorities, public health, and social care.
- A new duty on all NHS bodies – including ICBs, ICPs, and trusts – to the triple aim, of simultaneously pursuing:
  1. better care for all patients
  2. better health and wellbeing for everyone
  3. sustainable use of NHS resources.
- No reduction in existing Foundation Trust powers or legal duties, however, ICBs will have the authority to freeze capital spending for specific trusts if they are deemed to be operating outside the ICS's wider plans or not working co-operatively.
- Joint committees, pooled funds, and joint appointments.
- Ability to pool funds and budgets across health and local authorities, subject to guidance.

Londonwide view:

- Collaborative healthcare systems are, in principle, positive- allowing organisations and staff to work together across current, artificial boundaries.
- We are broadly supportive of the concept of joint committees, joint appointments, and, in certain cases, pooled funds, we strongly believe that any pooling of funding must not lead to NHS funding being used to plug gaps in other services, such as social care.
- We need more clarity over primary care budget protection to ensure that ICSs do not propose changes to the core contractual model for general practice, or attempt imposition of local variation of nationally agreed GMS contractual terms and conditions.
- References to the Triple Aim in the briefing and on the face of the Bill, rather than the Quadruple Aim, are concerning. The fourth aim is key: being able to work in a safe environment, able to eat, free from fear, scapegoating and bullying, free from abuse, with respect for the right to a family life. Whilst creating the conditions for the healthcare workforce to find joy and meaning in their work and in doing so, improving the experience of providing care, is also an aim, safety and freedom from abuse are far from the norm for many healthcare workers and must be prioritised.

3. **Competition and procurement**

- Removing competition requirements (repealing S75 of the Health and Social Care Act 2012) to allow commissioners to use the new Provider Selection Regime measures to determine whether to re-contract or go to competitive tender on service delivery contracts.
- Avoiding costly and disruptive tendering processes.
- Abolition of NHS Improvement's specific duties around competition and the prevention of anti-competitive behaviour.
- Ending much of the CMA's (Competition and Markets Authority) role within the NHS, removing NHS England's duty to refer contested licence conditions or National Tariff provisions to CMA.

Londonwide view:

- Welcome the measures to reduce bureaucracy and restrict access to contracts for (often small) independent contractor.
- Call for protections against immediate contract cancellation for current service providers .
- Important to find balance between removal of onerous paperwork and privatisation-creep which harms the public-service ethos of the NHS.
- Concerned that the proposed reforms are insufficient to fully protect the NHS from unnecessary private sector involvement and could, under the Provider Selection Regime, allow contracts to be awarded to private or other providers without proper scrutiny or transparency.
- To protect the NHS and prevent fragmentation of services, the NHS (including holders of PMS and GMS contracts for primary care services) should be made the default option for NHS contracts, with competitive tendering used only where an NHS provider cannot provide a service.

4. Workforce

- Measures may alter existing approaches to long-term planning and training, as well as the regulation of some NHS staff.
- Mandatory workforce reporting by the Secretary of State, at least once every five years – describing the system for assessing and meeting the workforce needs of the health service in England.
- LETBs will be abolished under the changes set out in the Bill, with their roles and responsibilities returning to HEE, to allow flexibility for regional operating models over time.
- Additional powers for the Secretary of State to move health care professionals into, or out of, regulation, and to abolish regulators under certain circumstances. (These changes are extremely unlikely to impact doctors and their existing model of professional regulation but may affect NHS managers).

Londonwide view:

- Ministers should retain/ hold political responsibility for staffing levels and be held to account for delivery of targets set in this area and for ensuring health and care systems have the workforce required to meet the needs of the population, now and in the future.
- We do not believe that the bill's existing requirement for the Health Secretary to report only on the system in place for assessing and meeting the workforce needs of the NHS every five years is sufficient.
- References to the Triple Aim in the briefing and on the face of the Bill, rather than the Quadruple Aim. The key is the fourth aim: creating the conditions for the healthcare workforce to find joy and meaning in their work and in doing so, improving the experience of providing care. https://qualitysafety.bmj.com/content/24/10/608
- We support the BMA's view that the Bill must include a responsibility for the Secretary of State to produce ongoing, accurate and transparent workforce assessments to directly inform recruitment needs. Also endorsed by the Health and Social Care Select Committee.

5. Data and information sharing

- Introduces a new duty for the Secretary of State to publish a report each Parliament describing the system in place for assessing and meeting the workforce needs of the NHS in England.
- NHS Digital has been given new powers to collect information about medicines and their effects in the UK to create a new medicine registry.
- The bill also introduces new requirements for private health and social care providers to share data with NHS Digital when asked. The explanatory notes state: "The effect of the amendment is to additionally enable [NHSD] to require private providers of health services to provide [it with] any information it requires in order to comply with a direction from the secretary of state under section 254 of the 2012 Act to establish an information system." With fines for those who fail to comply.
- Provides new powers for the Secretary of State to mandate standards for how data is collected and stored with the intention that this will allow a greater range of data sharing from a technical standpoint (related to data extracted under the currently controversial GPDfPR).
- Creation of a new offence, punishable by up to six months in prison, for sharing NHS data inappropriately.

Londonwide view:

- Broadly welcome efforts to improve information standards, but information standards need to be established collaboratively with providers/ data controllers ,particularly regarding what this could mean for healthcare providers and staff and their relationships with patients.
- We will be carefully considering the impact of the legislation to ensure that the appropriate safeguards for patient confidentiality are not undermined but remain concerned that there needs to be increased transparency and scrutiny of measures impacting on patient data protection, privacy and data usage.
- We are concerned that there appear to be blanket requirements to comply with data provision under direction, with no regard for the need for anonymisation (a point repeatedly made through the recent discussions about GPDfPR). Clause 19 provides powers to require information and gives NHSE a general power to require information from ICS. It doesn't explicitly say whether this includes personal data.
- It is not clear where the terms 'anonymised' or 'anonymous' are used if these mean the same as set out within Data Protection law.
- It is also of concern that Clause 81(3) wording has changed from '"the purposes of" to "purposes connected with" in regards to the dissemination of information: a much broader definition and a concern re future data uses, particularly as the draft bill makes NHSE the sole authority on NHS Digital's use of patient data and raises concerns over NHS Digital being a 'statutory safe haven' for patient data and the creation of a Trusted Research Environment (one of the three tests required for GPDfPR).
- Clause 86-87 on moving powers between bodies – no mention of protecting CAG (Confidentiality Advisory Group) of Health Research Agency, which is one of the safeguards for NHS Digital holding patient data.

6. Powers and accountability

- Expanding the Secretary of State for Health and Social Care's powers to include:
  - Direction of NHS England/Improvement by resetting the direction of the NHS outside the NHS Mandate.
  - Creation of new NHS Trusts, framed as a means of facilitating the rapid reorganisation of care when needed to support emergency provision, such as with the establishment of the Nightingale Hospitals.
  - Intervening in reconfiguration disputes at the request of Ministers (without being called in by other agencies)
  - Abolishing ALBs (Arm's Length Bodies)- this is partly intended to facilitate the formal merger of NHS England and NHS Improvement.
- A substantial portion of the Bill is focused on establishing new and greater powers for the Health Secretary which would significantly increase their direct power the over the NHS. The Government has characterised this as ensuring greater Parliamentary accountability over the health service.

Londonwide view:

- We agree with the BMA that while Ministers should ultimately be accountable in Parliament, the pandemic has shown how much can be achieved by putting NHS clinicians in the driving seat. Doctors must be trusted to lead and to deliver for the good of their patients and the whole health system.

- Timing is poor for rapid service transformation mid-pandemic.
- The powers conferred to the Health Secretary threaten NHS operational and clinical independence and run the risk of toxic politicisation of NHS rather than focus on day to day running of services. Instead of powers of "direction", why not "intervention", subject to Parliamentary scrutiny/ justification each time used? It is vital that the day-to-day running of the NHS is free from excessive political control and that long-term planning is not disrupted by changing political priorities.
- There is a risk that a lack of safeguards in the use of many of these powers could lead to greater power for the Secretary of State without sufficiently robust accountability to Parliament, or to the public. Currently, the Bill only outlines limited safeguards regarding the Health Secretary's powers to amend and abolish ALBs – more stringent measures are needed to limit the use and scope of these powers to prevent major changes being made to health bodies without scrutiny.

7. Wider proposals (public health and social care).

- In line with the Government's Obesity Strategy, the Bill includes specific plans to give the Secretary of State the authority to bring in new restrictions on the advertising of high fat, salt, and sugar foods on television, video on demand services, and online. Powers to alter food labelling requirements are also included.
- There are vey limited references to social care reform. However, several operational changes are included, including giving the Secretary of State powers to make payments and provide financial assistance to all social care providers. The Bill would also give the Health Secretary power to set or revise the CQC's objectives and priorities regarding the assessment of social care in Local Authorities – including indicators of quality.
- The Bill will make the HSSIB (Health Service Safety Investigations Body) a statutory body, with continued investigatory powers regarding safety incidents and a focus on "no liability" learning.
- The Bill will establish a statutory medical examiner system within the NHS in England and Wales, to scrutinise those deaths which do not involve a coroner. While not addressed in the Bill itself, NHS England is also intending to extend medical examiner scrutiny into primary care. (See Londonwide LMC's guidance on medical examiners here.)

Londonwide view:

- We recognise the value of the measures limiting the advertising of certain foods.
- The lack of detail regarding proposed/ planned social care reforms is a significant concern, given the interdependencies and reliance with general practice, the chronic underfunding, and the urgent need for action.
- Noting the creation of the HSSIB, we believe that there is a need for a body to whom general practice representatives can escalate concerns about unsafe pathway design, contracting and delivery (eg gaps in pathway, persistent poor interface etc). This goes hand in hand with our earlier calls for an independent appeals function to be sited at Governance level.
- Londonwide has several questions about the operational and financial impacts of extending the medical examiner system into primary care, and the relationships between existing services in London. We are currently pursuing these enquiries and will update guidance shortly, but there is a risk that in their current form there might be additional workload, delays during OOH and weekend periods (which may have particular significance if for religious or other reasons an MCCD is required within a short timeframe), and an increase in unscheduled and urgent workload.

About Londonwide Local Medical Committees (Londonwide LMCs)

Londonwide Local Medical Committees (Londonwide LMCs) is the clinically led independent voice of general practice in the capital, supporting Local Medical Committees; bodies recognised in statute (NHS Act) which represent the interests of all local GPs and their teams. We aim to secure the future of general practice in London through our work with all partners in the health and social care sector and beyond. We support and represent nearly 7,000 GPs and over 1,100 practice teams in London through our 27 locally elected committees. We ensure that London's GPs and their practice teams have access to the information and support they need to help them provide the best possible service to their nearly nine million patients.

We work with GPs across the breadth of their roles, from clinical provision to business services and patient engagement. GPs acknowledge the importance of engaging with patients in designing how to deliver services, making these as responsive as possible. We also recognise the power of information shared with patients in helping them make decisions about their treatment and to manage their own health through regular feedback at the practice, via technology, and through practice patient participation groups (PPGs).

Contacts

For further information please contact Sam Dowling, Director of Communications on sam.dowling@lmc.org.uk.

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FURTHER READING/ RESPONSES/ COMMENT ON BILL

- **LONDONWIDE LMCs**
  Response to provider selection regime consultation APRIL 2021
  Response to NHS England's ICS proposals IN LATE 2020
  Response to consultation on proposals to reform regulation of healthcare professionals

- **BMA**
  Press response issued on publication of the Bill
  Member briefing providing a summary of changes and initial analysis
  Response to provider selection regime consultation
  Response to NHS England's ICS proposals IN LATE 2020
  Dedicated Health and Care Bill webpage

- **NHS Confed**
  Member briefing providing a summary of changes and initial analysis

- **Commons Health and Social Care Committee Select Committee**
  Report on White Paper proposals for the reform of Health and Social Care
  Oral evidence session transcripts

DHSC/ NHSE CONSULTATIONS & STATEMENTS

- **DHSC press release, July 2021**
  https://www.gov.uk/government/news/health-and-care-bill-introduced-to-parliament.
- Provider Selection Regime, re rules on commissioning and competition.
- System Oversight Framework re regulation of statutoryICSs.
- ICS Design Framework setting out how ICSs are to prepare for statutory status.
- Regulating healthcare professionals, protecting the public setting out proposals affecting the UK regulatory landscape.