# 

# Health and Care Bill

Implications for the Healthwatch network



# Health and Care Bill

The Health and Care Bill, introduced into Parliament on 6 July, makes some significant changes to how NHS services are planned and commissioned, including reversing some of the changes made in the Health and Social Care Act 2012.

The bill is in six parts:

* Health service in England: integration, collaboration and other changes
* Health and adult social care: information
* Secretary of State's powers to transfer or delegate functions
* The Health Services Safety Investigations Body
* Miscellaneous
* General

The Department of Health and Social care has also produced [explanatory notes](https://publications.parliament.uk/pa/bills/cbill/58-02/0140/en/210140enlp.pdf).

# Part 1: Health service in England: integration, collaboration and other changes

The first part focuses on the way the NHS is structured. At a national level, it formally brings together NHS England and NHS Improvement (including the abolition of Monitor and the NHS Trust Development Authority). The NHS Mandate, which currently is produced on an annual basis, will be more flexible, and a mandate will remain in place until a new one has been developed. The legal duty for Healthwatch England to be consulted on the Mandate continues.

Funding for service integration puts in place standalone powers to enable the Better Care Fund to continue as it currently does without the requirement for an annual Mandate.

This part also includes a small but significant amendment to the National Health Service Act 2006, with the addition of “carers and representatives (if any)” alongside “individuals to whom the services are being or may be provided” as people who should be consulted by NHS England on its work.

The bill sets out the statutory basis for integrated care systems (ICSs), including integrated care boards (ICBs) and integrated care partnerships (ICPs). Every area of England is covered by an ICB, with no overlap of areas. This section also includes the abolition of clinical commissioning groups (CCGs).

Among the various duties placed on ICBs, transferred from CCGs, is Public involvement and consultation which also includes the addition of carers and their representatives. ICBs must prepare a plan setting out how they propose to exercise their functions – including public involvement and consultation – over the next five years. The ICB will need to consult with local people on the forward plan as well as consulting the Health and Wellbeing Board about whether the plan takes proper account of the local health and wellbeing strategy.

The ICB and partner local authorities will be responsible for setting up the ICP, bringing together health, social care, public health and, potentially, broader public services. The ICP will include, as a minimum, one member appointed by the ICB and one member appointed by each responsible local authority.

The ICP will produce a strategy to address the health, social care and public health needs of its area. The ICB and local authorities will have to have regard to that plan when making decisions.

This section also includes the Secretary of State’s function, including a requirement to publish a report describing the system in place for assessing and meeting the workforce needs of the health service. The Bill amends the NHS Act 2006 by inserting new sections which provide the Secretary of State with powers to give directions to NHS England regarding its functions, including public health.

There is a new power for the Secretary of State to give direction to NHS bodies or providers requiring a reconfiguration to be referred to them 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. This change will amend the current local authority power to refer to reflect the new process. This will not change the role of health overview and scrutiny.

The procurement reforms in the Bill enable the removal of the current procurement rules which apply to NHS and public health service commissioners when arranging clinical healthcare services, e.g., hospital or community services. It will enable the development of a new procurement regime for the NHS and public health procurement, informed by public consultation, reducing the need for competitive tendering where it adds limited or no value. The reforms apply only to healthcare services and not non-clinical services.

The bill removes the Competition and Markets Authority’s (CMA) ability to review NHS foundation trust mergers. Instead, NHS England will review mergers of NHS providers. The CMA will retain its functions in relation to regulating competition within the private healthcare market.

To align legislation with the new national ‘discharge to assess’ model for hospital discharge, the bill removes the requirement for social care needs assessments to be carried out by the relevant local authority before a patient is discharged from hospital. This will later be replaced by statutory guidance embedding existing guidance for assessment in the community.

It also removes the provisions which enable the responsible NHS body to charge the relevant local authority where a patient’s discharge from hospital has been delayed due to a failure of the local authority to arrange for a social care needs assessment. This is part of a shift away from ‘delayed transfers of care’ as a performance measure and development of new performance indicators, again alongside the new ‘discharge to assess’ pathway where people are discharged quickly as a matter of course and assessments are taking place in the community.

# Part 2: Health and adult social care: information

This part sets out what is required for information standards - a standard in relation to the processing of information (as opposed to as a document containing such standards) - around health and social care, including that an information standard must specify who it applies to.

An amendment to the 2012 act includes a new section relating to the sharing of anonymous information for purposes related to the functions of health or adult social care bodies in England. This requirement includes private providers.

A new paragraph requires the Health and Social Care Information Centre (NHS Digital) to have regard to the need to promote the effective and efficient planning, development and delivery of health services and adult social care in England when exercising its functions. An amendment is included so 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.

# Part 3: Secretary of State's powers to transfer or delegate functions

This part enables the Secretary of State to use regulation to transfer a function from one “relevant body to” another on the grounds of efficiency, effectiveness, economy or securing appropriate accountability to ministers. The relevant bodies are:

* Health Education England
* the Health and Social Care Information Centre (NHS Digital)
* the Health Research Authority
* the Human Fertilisation and Embryology Authority
* the Human Tissue Authority
* NHS England

The Secretary of State is unable to transfer a function of NHS England if this would make NHS England redundant. Modifying the functions could include:

* conferring a function on the body;
* abolishing a function of the body;
* changing the purpose or objective for which the body exercises a function;
* changing the conditions under which the body exercises a function.

# Part 4: The Health Services Safety Investigations Body

This part sets up the Health Services Safety Investigations Body (HSSIB) which will largely replace the Healthcare Safety Investigation Branch. HSSIB will be a Non-Departmental Public Body.

The purpose of the investigations is to:

* identify risks to the safety of patients, and
* address those risks by facilitating the improvement of systems and practices in providing NHS services or other health care services in England.

The purpose of the investigations does not include assessing or determining—

* blame,
* civil or criminal liability, or
* whether action needs to be taken in respect of an individual by a regulatory body.

The Bill creates a ‘safe space’ within which participants can provide information to the HSSIB for the purposes of an investigation without fear that HSSIB will disclose it to others. It prevents the HSSIB, or any individual connected with the HSSIB, from disclosing "protected material" held by the HSSIB in connection with its investigatory function.

# Part 5: Miscellaneous

The bill includes several provisions covering a variety of issues including:

## Social care:

* There is a new legal duty for the Care Quality Commission (CQC) to review and make an assessment of the performance of local authorities in discharging their ‘regulated care functions'.

## Professional regulation:

* The Secretary of State will have the ability to remove a profession that is currently regulated from statutory regulation when it is no longer required for public protection.
* The Secretary of State will also have the ability to abolish an individual health and care professional regulatory body where the profession continues to be regulated by another regulator.

## Medical examiners:

* Medical Examiners will provide independent scrutiny of deaths to reduce the potential for malpractice by doctors to go unchecked. Legislation will be amended so that Medical Examiners are appointed by NHS bodies rather than local authorities.

## Advertising of less healthy food and drink:

* A 9:00 pm watershed for less healthy food or drink advertising on TV and a prohibition of paid-for less healthy food or drink advertising online, will simultaneously be introduced at the end of 2022. On-Demand Programme Services that OFCOM regulates will also be included in the TV watershed.

## Hospital Food Standards:

* The Secretary of State will have the power to make regulations imposing requirements in connection with the provision of food or drink provided on hospital premises relating to food or drink provided or sold to patients, staff, visitors or anyone else on hospital premises.

## Food information for consumers:

* The Secretary of State will be able to amend requirements on food information and labelling contained in EU legislation outlining hospital food standards and for information for consumers.

## Fluoridation of water supplies:

* The bill gives the Secretary of State the power to directly introduce, vary or terminate water fluoridation schemes. This power will allow DHSC to streamline processes and take responsibility for proposing any new fluoridation schemes, which will be subject to consultation and funding being agreed.

# Part 6: General

This part includes a power which allows the Secretary of State, by regulations, to amend, repeal, revoke or otherwise modify any provision within the bill or any provision made by or under primary legislation passed or made either before this Act is passed or later in the same parliamentary session.

# What this means for Healthwatch

The Health and Care Bill does not set out every element in detail. This means that some aspects will be subject to further guidance while some other issues will be left to local determination. Although being able to make decisions locally should mean that ICSs can take account of local circumstances, it does also mean that there is a risk of inconsistency.

## Public voice

The bill does not set out how the views of local people will be heard by the ICS, although there will be a requirement to have a plan for engagement. The bill does not stipulate how – or whether - public representation will be included in the structure of the ICS at either board (ICB) or partnership (ICP) level.

As arrangements will be made at a local level, Healthwatch will need to demonstrate the importance of people’s voices being heard and Healthwatch’s role in supporting that. Healthwatch will need to ensure that local voices are listened to when commissioning decisions are made. As there will no longer be a requirement for procurement, there is a risk that arrangements will continue without the opportunity for local views to be taken into account.

Healthwatch will be particularly interested in how local Healthwatch and the wider voluntary community and social enterprise (VCSE) sector is represented both at the overall ICS level and also at local authority (or Place level).

## Powers of the Secretary of State

The increased powers of the Secretary of State carry the risk of centralisation. One area that will be of interest to Healthwatch is the ability to intervene at an earlier stage in service reconfiguration. Currently, the expectation is that reconfiguration issues – for example, hospital closure or significant service changes – are expected to be tackled locally and referred to the Secretary of State at a late stage. The new process will be brought in under regulations rather than as part of the act. Healthwatch will want to see a process that ensures that the voices of local people are heard and given due regard.

# Key questions

* How will public voice be represented across the Integrated Care System (ICS), including at Board (ICB) and Partnership (ICP) level?
* How will the ICS demonstrate that the views of local people are being appropriately taken into account by the ICS?
* How will the ICS ensure that its plans properly reflects the needs of the diversity of the population of the area?