HOUSE OF LORDS Library Briefing

Health and Care Bill
HL Bill 71 of 2021–22

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On 7 December 2021, the second reading of the Health and Care Bill is scheduled to take place in the House of Lords.

The bill gives effect to policies set out as part of NHS England's recommendations for legislative reform following the Long Term Plan and the Integration and Innovation white paper. It would abolish clinical commissioning groups and replace them with integrated care boards (ICBs) to commission hospital and other health services. It would establish integrated care partnerships (ICPs) to bring together ICBs and local authorities to produce an integrated care strategy for their area. NHS England and NHS Improvement would be merged. New powers would be given to the secretary of state, including the power to direct NHS England, to intervene earlier in the reconfiguration of local NHS services, and to transfer functions between NHS bodies. The NHS would no longer be subject to competitive tendering requirements and enforced competition between NHS providers.

The bill contains many other measures, including: setting mandatory information standards for data across the health and adult social care system; establishing the Health Services Safety Investigations Board as a statutory body; making virginity testing an offence; and restricting the advertising of less healthy food and drinks on television, on-demand programme services and online.

Following a government amendment to the bill at report stage in the House of Commons, means-tested financial support provided by a local authority towards an individual's personal care costs would not count towards the new £86,000 cap on care costs. This amendment to the bill was controversial.

Other concerns raised about the bill have centred on the level of involvement that private healthcare companies would be able to have in ICBs and the level of transparency in awarding contracts under a new procurement regime. The bill has also been criticised for introducing a major reorganisation of the NHS while it is still dealing with the effects of the coronavirus pandemic, and for not doing enough to address staffing shortfalls in the NHS and the social care sector. The Government sought to address some concerns about the bill through amendments during its passage through the House of Commons, but the Labour Party and others argue these amendments did not go far enough.

This briefing focuses on how the bill changed as it went through the House of Commons, and remaining areas that opposition parties and other stakeholders would like to see addressed in the House of Lords.

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1. What does the bill do?

The Health and Care Bill had its first reading in the House of Lords on 24 November 2021 and is scheduled for its second reading on 7 December 2021. It is a wide-ranging bill. As introduced in the Lords, it consists of 154 clauses, split into seven parts, with 17 schedules.

This briefing should be read in conjunction with the explanatory notes to the bill[1] and the House of Commons Library briefing, *Health and Care Bill 2021–22* (12 July 2021), both of which set out more background and detail about the bill's provisions. The Government produced a series of factsheets covering different elements of the bill which also provide background information about the policy intention behind its provisions.

This briefing focuses on how the bill was changed in the House of Commons, and remaining areas that opposition parties and other stakeholders would like to see addressed in the House of Lords.

1.1 Purpose of the bill

The Government says the purpose of the bill is to give effect to policies set out as part of NHS England's recommendations for legislative reform following the Long Term Plan, published in January 2019, and in the white paper Integration and Innovation: Working Together to Improve Health and Social Care for All, published in February 2021.[2]

The bill also contains provisions intended to support social care, public health and quality and safety in the NHS. The Government says they are designed to address specific problems or remove barriers to delivery, maximise opportunities for improvement and have, in most cases, been informed by the experience of the pandemic.[3] Provisions to make the practice of virginity testing an offence were added to the bill at report stage in the House of Commons.

1.2 Background: NHS Long Term Plan and Innovation and Integration white paper

The NHS Long Term Plan set out how local NHS organisations in England

[1] At the time of writing this briefing, explanatory notes to accompany the bill as introduced in the House of Lords had not yet been published. References to the explanatory notes are to the version published to accompany the bill as introduced in the House of Commons in July 2021. This briefing indicates where the clause numbering of the bill has changed since then.

[2] Explanatory Notes, para 1. NHS, *The NHS Long Term Plan*, January 2019; and Department of Health and Social Care, *Integration and Innovation: Working Together to Improve Health and Social Care for All*, 11 February 2021.

[3] Explanatory Notes, para 4.

would "increasingly focus on population health" by moving to integrated care systems (ICSs) everywhere.[4] It explained an ICS "brings together local organisations to redesign care and improve population health, creating shared leadership and action". An ICS enables the integration of primary and specialist care, of physical and mental health services, and of health and social care. The ICS model was presented as "central to the delivery of the Long Term Plan".

The Long Term Plan stated that the proposals could be implemented without legislative changes, but that amending the law would be beneficial:

> […] our view is that amendment to primary legislation would significantly accelerate progress on service integration, on administrative efficiency, and on public accountability. We recommend changes to: create publicly accountable integrated care locally; to streamline the national administrative structures of the NHS; and remove the overly rigid competition and procurement regime applied to the NHS.[5]

ICSs are already operating in the NHS in England as voluntary partnerships, on a non-statutory basis. In 2016, NHS England asked all parts of England to begin planning together in new partnerships formed of all NHS organisations, local government and others, setting out their early thinking and working with partners to develop them.[6] In 2018, NHS England named those parts of the country that had advanced furthest towards this as the first integrated care systems, with NHS England working closely with them to pioneer best practice. In 2019, the NHS Long Term Plan set the ambition for all parts of the country to become integrated care systems by April 2021. In April 2021, the chief executive of NHS England declared all 42 parts of England as integrated care systems.[7]

The thinktank the King's Fund has noted that the voluntary nature of the current ICS partnerships "rest[s] on the willingness and commitment of organisations and leaders to work collaboratively".[8] It assessed that progress has sometimes been achieved through complex workarounds to the current legislative framework, and that this sometimes leads to "duplication and protracted decision-making".

The Integration and Innovation white paper confirmed that a Health and Care Bill would make legislative changes to support these organisational

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[4] NHS, *The NHS Long Term Plan*, January 2019, p 29.
[5] ibid, p 10.
[6] NHS, 'The journey to integrated care systems in every area', accessed 1 December 2021.
[7] ibid. The areas are listed on the NHS's 'Integrated care in your area' webpage.
[8] The King's Fund, 'Integrated care systems explained: making sense of systems, places and neighbourhoods', 11 May 2021.

changes within the NHS:

> There are […] two forms of integration that will be underpinned by the legislation: integration within the NHS to remove some of the cumbersome boundaries to collaboration and to make working together an organising principle; and greater collaboration between the NHS and local government, as well as wider delivery partners, to deliver improved outcomes to health and wellbeing for local people.
>
> The NHS and local authorities will be given a duty to collaborate with each other. We will also bring forward measures for statutory integrated care systems (ICSs). These will be comprised of an ICS Health and Care Partnership [now referred to in the bill as integrated care partnership or ICP], bringing together the NHS, local government and partners, and an ICS NHS Body [now referred to in the bill as integrated care board or ICB]. The ICS NHS body will be responsible for the day to day running of the ICS, while the ICS Health and Care Partnership will bring together systems to support integration and develop a plan to address the systems' health, public health and social care needs. […] The legislation will avoid a one-size-fits-all approach but enable flexibility for local areas to determine the best system arrangements for them. A key responsibility for these systems will be to support place-based joint working between the NHS, local government, community health services, and other partners such as the voluntary and community sector. Frequently, place-level commissioning within an integrated care system will align geographically to a local authority boundary […][9]

The white paper also set out other changes to be made in the bill, including:[10]

- Reforming the way competition law and procurement regulations apply to the NHS in the Health and Social Care Act 2012.
- A statutory merger of NHS England and NHS Improvement, with enhanced powers of direction for the Government over the new body.
- Reforming the mandate of NHS England to allow more flexibility over timing.
- Power to transfer functions between arm's-length bodies.
- New assurance framework for local authority delivery of adult social care.
- Improved data collection in the social care system.

[9] Department of Health and Social Care, *Integration and Innovation: Working Together to Improve Health and Social Care for All*, 11 February 2021, pp 10–11.
[10] ibid, pp 11–13.

- Greater clarity over responsibility for workforce planning.
- Power for ministers to determine service reconfigurations earlier in the process.
- Enhanced assurance framework in social care.
- Public health measures to tackle obesity, including restrictions on the advertising of high-fat, -salt and -sugar foods.
- Moving responsibility for water fluoridation from local authorities to central government.
- Putting the Health Services Safety Investigations Body on a statutory footing.
- Establishing a statutory system of medical examiners.
- Powers to enable the implementation of reciprocal healthcare agreements with countries around the world.

1.3 Summary of the bill's main provisions

Part 1 (clauses 1–80 and schedules 1–12) deals with integration, collaboration and other changes to the health service in England. It includes many of the provisions set out in the white paper. Key provisions in part 1 include:

- Merging NHS England, Monitor and the NHS Trust Development Authority (TDA) into one organisation formally called NHS England (clause 1 and clauses 29–34). NHS England's formal name currently is the NHS Commissioning Board. Monitor and the NHS Development Trust currently operate together as a single organisation known as NHS Improvement.
- Allowing greater flexibility in setting the NHS mandate so it would no longer have to align with the annual financial cycle (clause 3).
- Abolishing the statutory basis for clinical commissioning groups (clause 13).
- Placing a duty on NHS England to establish integrated care boards (ICBs) to cover the whole of England, without any overlap between different ICBs (clause 14).
- Giving ICBs functions in relation to commissioning hospital and other health services for the people for whom the ICB has responsibility and placing a range of other duties on them (clauses 14–17 and 20).
- Creating a duty for ICBs and each responsible local authority whose area falls wholly or partly within the ICB's area to establish a joint committee for the board's area (clause 21). This committee would be known as an 'integrated care partnership' (ICP). The ICP would be required to produce an integrated care strategy, and local authorities and their partner ICPs would be required to have regard to it in exercising their functions.

- Placing a new duty on NHS England, ICBs, NHS trusts and NHS foundation trusts to have regard to the health and wellbeing of the population, the quality of services provided, and efficient and sustainable use of resources (clauses 5, 16, 45 and 59). This is known as the 'triple aim'.
- Establishing financial controls on the new integrated care system, with a view to ensuring that expenditure by NHS England and ICBs does not exceed the aggregate amount they receive each year, and that the capital and resource expenditure of NHS England, ICBs, NHS trusts and foundation trusts does not exceed the limits specified by the secretary of state (clauses 22–25).
- Placing a duty on the Care Quality Commission (CQC) to carry out reviews and assessments into the overall functioning for the provision of NHS care and adult social care services within the area of each ICB (clause 26).
- Giving new or extended functions to the secretary of state, including:

    - A duty to publish at least once every five years a report describing the system in place for assessing and meeting the workforce needs of the NHS in England (clause 35).
    - The ability to arrange for any of the secretary of state's public health functions to be exercised by NHS England, an ICB, a local authority, a combined authority or any other body specified in regulations (clause 36).
    - The power to direct NHS England or an ICB to exercise the secretary of state's public health functions (clause 37).
    - The power to direct NHS England or any other public body to exercise any of the healthcare safety investigation functions which are specified in the direction (clause 38).
    - A general power to direct NHS England in relation to any of its functions (clause 39).
    - Powers to intervene earlier in the reconfiguration of NHS services (clause 40 and schedule 6).

- Replacing the national tariff that sets the prices commissioners pay to providers with a new NHS payment scheme that would set rules on how commissioners would establish what prices to pay providers (clause 68 and schedule 10).
- Repealing requirements introduced under section 75 of the Health and Social Care Act 2012 for contracts to be competitively tendered and creating powers to develop a new procurement regime for the NHS and public health procurement (clauses 70 and 71).
- Removing the Competition and Markets Authority (CMA) and Monitor's formal roles in enforcing competition between NHS providers (clauses 72–75 and schedule 12).

Part 2 (clauses 81–87) contains provisions intended to enable increased sharing and more effective use of data across the health and adult social care system.[11] The legislation aims to enable the Department of Health and Social Care (DHSC) and NHS England to publish mandatory information standards which providers of health or adult social care would have to comply with. The Government intends to extend the potential application of information standards to include private providers.

Part 3 (clauses 88–94) sets out powers for the secretary of state to transfer functions between certain arm's length bodies (Health Education England, the Health and Social Care Information Centre (known as NHS Digital), the Health Research Authority, the Human Fertilisation and Embryology Authority, the Human Tissue Authority and NHS England).[12] It would also give the secretary of state powers to delegate (but not permanently transfer) their own functions to these bodies.

Part 4 (clauses 95–121 and schedules 13 and 14) would establish the Health Services Safety Investigations Board as a statutory body.

Part 5 (clauses 122–134 and schedule 16) would make virginity testing an offence. This part was added to the bill at report stage in the House of Commons.

Part 6 (clauses 135–148 and schedule 17) contains miscellaneous provisions, including:

- An amendment to the Healthcare (European Economic Area and Switzerland Arrangements) Act 2019 to enable the Government to implement reciprocal healthcare arrangements with countries outside the EEA and Switzerland.
- A new duty on the Care Quality Commission (CQC) to assess local authorities' delivery of their adult social care functions under part 1 of the Care Act 2014 and a power for the secretary of state to intervene where a local authority is failing.
- Provision that financial support provided by a local authority towards personal care costs would not count towards the new £86,000 cap on care costs due to come into effect in 2023. A cap was provided for in the Care Act 2014 but has not yet been implemented.
- Powers to amend professional regulation regimes maintained by various health and care regulatory bodies, for instance to remove a profession from regulation where regulation is no longer

[11] Explanatory Notes, paras 64–80.
[12] The Government announced plans in November 2021 to merge Health Education England and NHS Digital into NHS England once legislation allows (Department of Health and Social Care, 'Major reforms to NHS workforce planning and tech agenda', 22 November 2021).

required for public protection or to regulate new groups of workers concerned with health and care.

- Creation of a statutory medical examiner system within the NHS rather than local authorities in England, to scrutinise all deaths that do not involve a coroner.
- Restrictions on the advertising of less healthy food and drink on television, on on-demand programme services and online.
- Powers to adopt statutory requirements on hospital food in England.
- Powers for the secretary of state to directly introduce, vary or terminate water fluoridation schemes in England.

Part 7 (clauses 149–154) contains provisions relating to regulations, financial provision, extent, commencement and short title, as well as consequential provisions.

Healthcare is a devolved matter. The majority of the bill's provisions extend to England and Wales and apply in England only. Clause 152 provides that the following extend to England and Wales, Scotland and Northern Ireland:

- Paragraphs 1(3) and (4) of schedule 1: these relate to renaming the NHS Commissioning Board as NHS England.
- Part 3: the secretary of state's powers to transfer or delegate functions.
- Clause 111: restriction of statutory powers requiring disclosure of information by the Health Services Safety Investigations Board.
- Part 7.

Clauses 126–129 extend to Scotland only; these relate to virginity testing offences in Scotland. Likewise, clauses 130–133 extend to Northern Ireland only; these relate to virginity testing offences in Northern Ireland.

Clause 152 also provides that an amendment, repeal or revision made to existing legislation has the same extent as the provision amended, repealed or revoked. For instance, clause 136 would make amendments to the Healthcare (European Economic Area and Switzerland Arrangements) Act 2019. That act extends to England and Wales, Scotland and Northern Ireland.

The bill's explanatory notes set out more detailed information about the territorial extent and application of the provisions.

2. How did the bill change in the House of Commons?

2.1 Committee stage

At committee stage in the House of Commons, four new clauses tabled by the Government were added to the bill, with the following effect:[13]

- To put a duty on the CQC to carry out reviews and assessments into the overall provision of NHS care and adult social care services within each ICB area (now clause 26 in the bill as introduced in the House of Lords).
- To create a new power for the secretary of state to intervene where local authorities are failing in the exercise of functions under part 1 of the Care Act 2014 (adult social care) and make consequential amendments (now clause 138).
- To remove the CQC's power (under section 50 of the Health and Social Care Act 2008) to give an English local authority a notice of failure for not providing a service (now clause 139).
- To provide for circumstances where community pharmacies and other dispensing services do not have to be paid to supply medicines because stocks have been centrally purchased by the NHS (community pharmacists and dispensing doctors are usually paid to cover the cost of purchasing medicines they dispense). (This clause was later removed at report stage and replaced with another that also included corresponding provision in Wales; this now appears in the House of Lords version of the bill as clause 135).

A number of technical government amendments were also made at committee stage. No non-government amendments were made. The committee stage proceedings are covered in further detail in the House of Commons Library briefing, *Health and Care Bill: Committee Stage Report* (18 November 2021).

2.2 Report stage

Nearly 60 government amendments were made to the bill at report stage, which took place over two days on 22 and 23 November 2021.[14] Many of these were described by the Government as minor or technical.

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[13] House of Commons Library, *Health and Care Bill: Committee Stage Report*, 18 November 2021, p 7. Full details of all the public bill committee sittings are available in: Public Bill Committee, *Health and Care Bill*, 2 November 2021 (compilation of all sittings).

[14] HC *Hansard*, 22 November 2021, cols 48–166; and HC *Hansard*, 23 November 2021, cols 201–309.

The main changes made by the government amendments were to:

- Specify that for individuals who receive financial support towards their care costs from the local authority, only the amount the individual contributes would count towards the new £86,000 cap on care costs (now clause 140 in the bill as introduced in the Lords).
- Clarify the restrictions on advertising less healthy food and drinks (schedule 17).
- Prevent individuals from being appointed as a member of an ICB 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" (schedule 2).
- Make virginity testing an offence (part 5).

The Government accepted amendments from three backbench Conservative MPs on:

- priorities for the CQC when assessing ICBs (clause 26 in the bill as introduced to the Lords);
- ICB plans for addressing the needs of victims of abuse (clause 20); and
- including cancer outcome targets in the NHS mandate (clause 4).

Further detail on all these amendments is set out below.

2.2.1 Government amendments made to the bill

Cap on care costs for charging purposes

In September 2021, the Government announced new plans for funding adult social care.[15] It said £3.6 billion raised from a new health and social care levy would be used over the next three years to reform how people pay for care, including a cap on care costs. From October 2023, the Government will introduce a new £86,000 cap on the amount anyone in England will need to spend on their personal care over their lifetime.[16] The Care Act 2014 already provides a legislative framework for capping care costs, following the recommendations of the Dilnot Commission in 2011.[17]

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[15] Prime Minister's Office, 'PM statement to the House of Commons on health and social care', 7 September 2021.
[16] Department of Health and Social Care, *Build Back Better: Our Plan for Health and Social Care*, published 7 September 2021, updated 19 November 2021.
[17] See House of Commons Library, *Proposed Reforms to Adult Social Care (Including Cap on Care Costs)* (24 November 2021) for further details.

Under the framework as originally legislated for in the Care Act 2014, if a local authority is meeting a person's social care needs, the cost to the local authority of doing so counts towards the cap.[18] However, the Government announced on 17 November 2021 that it intended to amend how the existing provisions of the Care Act 2014 apply to the way that people within the means test progress towards the care cap:

> This amendment, subject to parliamentary approval, will ensure that only the amount that the individual contributes towards these costs will count towards the cap on care costs, and people do not reach the cap at an artificially faster rate than what they contribute. The much more generous means test is the main means of helping people with lower levels of assets.[19]

The Government tabled new clause 49 at report stage in the House of Commons to make this amendment. It was agreed to on division and now appears in the bill as clause 140. The new clause would mean that for individuals who receive financial support towards their care costs from the local authority, only the amount the individual contributes would count towards the £86,000 cap, not any contribution by the local authority. For both those in receipt of financial support and self-funders, their individual contribution would be calculated on the basis of the 'local authority rate', ie the amount it would have cost the local authority if it had been meeting their eligible needs. Any top-up fees paid by the individual above the local authority rate would not count towards reaching the cap.

The Government argues that this should be seen in the context of the overall package on capping care costs, which includes more generous means-testing for local authority financial support:

> Anyone with assets of between £20,000 and £100,000 will be eligible for some means-tested support, helping people without substantial assets. The new upper capital limit of £100,000 is more than four times the current limit of £23,250, ensuring that many more people are eligible for some means-tested local authority support.
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> If someone needs care, local authorities will assess i) their care needs and which of those needs are eligible to be met by the Local Authority and ii) whether they should receive financial support to help with care costs, via a means test assessment. Like the current system, the means test will be based on total assets, including both the value of a person's home and their savings. However, if a person needs to continue to live in their own home, it will be excluded from the assessment of total

[18] House of Commons Library, *Proposed Reforms to Adult Social Care (Including Cap on Care Costs)*, 24 November 2021, p 16.
[19] Department of Health and Social Care, 'Adult social care charging reform: further details', updated 19 November 2021.

chargeable assets. This is known as the housing disregard and is unchanged from the current rules.

The new means test for adult social care will come into effect in October 2023 on the basis of a person's income and savings in the following way.

- If a person's **total assets are over £100,000**, full fees must be paid. The maximum that a person will have to pay over their lifetime towards personal care costs will be £86,000 as a result of the new cap. If by contributing towards care costs, the value of a person's remaining assets falls below £100,000, they are likely to be eligible for some financial support. Once the £86,000 cap is reached, local authorities will pay for all eligible personal care costs. No-one will need to make a contribution from their income towards these care costs. People may choose to "top up" their care costs by paying the difference towards a more expensive service, but this will not count towards the cap.
- If a person's **total assets are between £20,000 and £100,000**, their local authority is likely to fund some of their care. People will be expected to contribute towards the cost of their care from their income, but if that is not sufficient, they will contribute no more than 20 per cent of their chargeable assets per year. If by contributing towards care costs, the value of a person's remaining assets falls below £20,000, then they would continue to pay a contribution from their income but nothing further from their assets.
- If a person's total **assets are less than £20,000**, they will not have to pay anything for their care from their assets. However, people may still need to make a contribution towards their care costs from their income.[20]

The overall package also addresses the level of minimum income guarantee and daily living costs:

To allow people receiving means-tested support to keep more of their own income, the government will unfreeze the minimum income guarantee (MIG) for those receiving care in their own homes and personal expenses allowance (PEA) for care home residents, so that from April 2022 they will both rise in line with inflation.

The cap will not cover the daily living costs (DLCs) for people in care homes, and people will remain responsible for their daily living costs throughout their care journey, including after they reach the cap. For

[20] Department of Health and Social Care, *Build Back Better: Our Plan for Health and Social Care*, published 7 September 2021, updated 19 November 2021.

> simplicity, these costs will be set at a national, notional amount of £200 per week. DLCs are a notional amount to reflect that a proportion of residential care fees are not directly linked to personal care, like rent, food and utility bills and would have had to be paid wherever someone lives. This is in line with the Commission on Funding of Care and Support's 2011 recommendation. The £200 level is £30 less than a proposal set out in 2015, ensuring people get to keep more of their income and assets.[21]

The day after the Government announced its intention to exclude local authority contributions from progress towards the cap, Sir Andrew Dilnot told the House of Commons Treasury Committee it would mean that less well-off people "would hit the cap significantly later in time, having spent exactly the same amount of money" as better-off peers with the same level of care need.[22] He said that:

> Essentially, what this change does is that, for those who have long care journeys or significant care needs, the less well-off will not gain any benefit from the cap. The only change as a result of all of these reforms will be that, instead of running your assets down to your last £14,250, you would run your assets down to your last £20,000.
>
> The people who are most harshly affected by this change will be those with assets of exactly £106,000—that is the £86,000 of cap plus £20,000 that is protected by the means-tested system. Everybody with assets of less than £186,000 would do less well under what the Government are proposing than the proposals that we made structurally and those that are legislated for. That is a big change that was announced yesterday, and it is disappointing. It finds savings exclusively from the less well-off group.[23]

He said that the change would "tend to hit people in regions of the country with lower house prices harder than it does those in regions with higher house prices".[24]

Following the evidence session, the Treasury Committee asked the Government for distributional and regional impact analyses of the change.[25] In response, Sajid Javid, Secretary of State for Health and Social Care, said the full impact assessment of the Government's proposals would be

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[21] Department of Health and Social Care, *Build Back Better: Our Plan for Health and Social Care*, published 7 September 2021, updated 19 November 2021.
[22] House of Commons Treasury Committee, *Oral Evidence: Autumn Budget and Spending Review 2021*, 18 November 2021, HC 825 of session 2021–22, Q310.
[23] ibid.
[24] ibid, Q323.
[25] House of Commons Treasury Committee, 'Letter from Treasury Committee chair to Chancellor relating to social care funding announcement', 18 November 2021.

published in early 2022.[26] He said the Government's calculations suggested that not proceeding with the change made by the amendment would cost in the region of £900 million. He also argued that Sir Andrew Dilnot's analysis would not apply in the majority of cases, and that nobody would be worse off than under the current system:

> Sir Andrew's evidence focused on what the maximum level of asset depletion that somebody could theoretically face if they received care for an infinitely long period of time. On 19 November I published analysis which compares the Government proposals with the 2015 proposals […] It looks at what the situation would be for somebody experiencing an average length residential care journey and one experiencing a very long, ten-year one. It shows it is highly unlikely that anybody within the means test would deplete their assets to anywhere near that maximum level.
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> […] It is important to reiterate, however, that nobody will be worse off under the system we are proposing than the one currently in operation. Our plans are just as good as what was proposed in 2015 for care recipients with less than £100,000 of assets with average length care journeys, and better for people in domiciliary care or whose partners still live in their home.[27]

Speaking to the new clause at the bill's report stage, Edward Argar, Minister for Health, described the Government's £86,000 cap on personal care costs as a "seismic and historic change in the way we pay for care in England".[28] He said this cap, together with other changes, would make the existing means test "far more generous":

> We are increasing the upper capital limit from £23,250 to £100,000, which will make masses of people with moderate assets eligible for some state support towards the cost of care earlier, and the lower capital limit will also increase, from £14,250 to £20,000. Below that level, people will contribute only from their income, fully protecting their savings and assets below £20,000.

Mr Argar said the Government had "always intended for the cap to apply to what people personally contribute, rather than on the combination of their personal contribution with that of the state".[29] He acknowledged this would mean that people with fewer assets would reach the cap more slowly than

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[26] House of Commons Treasury Committee, 'Correspondence from the Secretary of State for Health and Social Care regarding social care funding impact assessment', 22 November 2021.
[27] ibid. The analysis referred to is: Department of Health and Social Care, *Adult Social Care Charging Reform: Analysis*, 19 November 2021.
[28] HC *Hansard*, 22 November 2021, col 109.
[29] ibid, col 110.

those who were entirely self-funding. He said the amendment would make it "simpler to understand the amount that will go towards the cap and make it fairer". He emphasised that "nobody—nobody—will be 'worse off' than under the current system". The Government calculated that currently around half of all older adults in care received some state support for their care costs, and this would rise to roughly two thirds under the reforms.[30]

Justin Madders, Shadow Minister for Health and Social Care, said it was "wholly wrong to bring such a fundamental change forward as a last-minute addition to this bill", with no impact assessment and no mention of the amendment at committee stage.[31] He described it as "wholly regressive" to "give support through means-testing, but then to penalise people later for receiving it in the first place". He said the proposal would "[exacerbate] regional inequalities through an unfair tax" and was not a plan to fix social care.[32] He characterised the new clause as "a reverse Robin Hood situation", whereby people on lower incomes would "pay into a system that they will see little benefit from, but that will protect 90% of a property worth £1 million".[33]

Jeremy Hunt (Conservative MP for South-West Surrey and chair of the House of Commons Health and Social Care Committee) said the Government's package on social care capping was "a step forward" but "nothing like as progressive as we had hoped".[34] He expressed concern that focusing on what does or does not contribute to the cap was to miss "the fundamental problem in social care", namely the amount of funding for local authorities.

Philippa Whitford, shadow Scottish National Party spokesperson for health and social care, said it was "completely misleading" of the Government to say that nobody would have to pay more than £86,000 for social care, as accommodation costs would not count towards the cap.[35] While personal care costs would count towards the cap, she noted that personal care was provided free in Scotland.[36]

Daisy Cooper, deputy leader of the Liberal Democrats, said it was "unforgiveable" the Government had "sneaked out" the new clause "in a move that changed the goalposts" and would affect "struggling families".[37]

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[30] HC *Hansard*, 22 November 2021, col 111.
[31] ibid, col 123.
[32] ibid, col 124.
[33] ibid, col 125.
[34] ibid, col 127.
[35] ibid.
[36] ibid, col 128.
[37] ibid, col 139.

New clause 49 was agreed to on division by 272 votes to 246, a majority of 26.[38]

Further coverage of reaction to the social care funding reform package and to new clause 49 specifically is set out in the House of Commons Library briefing, *Proposed Reforms to Adult Social Care (Including Cap on Care Costs)* (24 November 2021).

Advertising of less healthy food and drink

Clause 144 and schedule 17 contain measures relating to the advertising of less healthy food and drink. The explanatory notes explain:

> The intention of this bill is to reduce children's exposure to the advertising of less healthy food and drink products on TV and online. This bill will introduce a 9pm watershed for less healthy food and drink advertising on TV and a prohibition of paid-for less healthy food and drink advertising online, simultaneously, at the end of 2022.[39]

Several government amendments to the provisions in schedule 17 (as numbered in the Lords version of the bill) on the advertising of less healthy food and drink were agreed to without division.[40] The effect of these amendments is that:

- The secretary of state must consult persons they consider appropriate before making any changes to the use of the nutrient profiling technical guidance of January 2011.[41] This guidance is referred to in schedule 16 as the "relevant guidance" and is also referred to as the nutrient profiling model (NPM). It is used as one part of a two-part test to determine if a food or drink product falls into the 'less healthy' category and would therefore be covered by the new advertising restrictions for television programmes, on-demand programmes and paid-for online advertising. The other part of the test is that the product falls within a description specified in regulations made by the secretary of state. The minister explained that work had been under way over the last few years to update the NPM in line with updated dietary recommendations, but the Government did not currently intend to apply the updated model to the advertising restrictions policy.[42]

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[38] HC *Hansard*, 22 November 2021, col 153.
[39] Explanatory Notes, para 184.
[40] Amendments 31–39. HC *Hansard*, 22 November 2021, cols 97–8.
[41] Department of Health, *Nutrient Profiling Technical Guidance*, January 2011.
[42] HC *Hansard*, 22 November 2021, cols 81–2.

- The definition of an advertisement placed on television and on-demand programme services would include sponsorship credits around programmes and sponsorship announcements. Edward Argar said this would "in effect prohibit identifiable less healthy food and drink products from sponsoring programmes before the watershed".[43]
- UK businesses producing online advertisements intended to be accessed principally by audiences outside the UK would be exempt from the bill's advertising restrictions.[44]

Alex Norris, Shadow Minister for Health and Social Care, said the proposed watershed on advertising high-fat, -sugar and -salt (HFSS) products was "broadly a good thing", and Labour therefore did not oppose the government amendments.[45]

However, he described the ban on paid-for online advertising of HFSS products as "a blunt tool in pursuit of an important goal". He said he was surprised the Government was showing little interest in exploring "creative alternatives" to regulating online advertising, such as amendments tabled by Richard Fuller (Conservative MP for North East Bedfordshire) and Greg Smith (Conservative MP for Buckingham). Greg Smith's amendments proposed that online platforms carrying advertising would be treated in the same way as broadcasters, rather than responsibility for online advertising resting with the advertiser.[46] Richard Fuller's would have required advertisers to restrict the online advertising of HFSS to children by using targeting filters and tools.[47]

Edward Argar said the Government considered approaches that relied on targeting to be "potentially insufficient to meet the policy objectives".[48] He said the Government's approach "best aligns with the current enforcement frameworks across TV, online and on-demand programme services advertising".

Integrated Care Boards

Clauses 13–20 and schedules 2 and 3 would establish integrated care boards (ICBs) and set out their functions. The bill would remove the statutory basis for clinical commissioning groups (CCGs) and place a duty on NHS England to establish ICBs to cover the whole of England, without any

[43] HC *Hansard*, 22 November 2021, col 85.
[44] ibid.
[45] ibid, col 64.
[46] ibid, cols 57–8. The relevant amendments were 106–9.
[47] ibid, col 67. The relevant amendment was new clause 14.
[48] ibid, col 83.

overlap between the areas covered by different ICBs. The explanatory notes set out how ICBs are intended to operate:

> The ICB will take on the commissioning functions of the CCGs [clinical commissioning groups] as well as some of NHS England's commissioning functions. However, an ICB will not simply be a larger CCG and is expected to work differently in practice—its governance model reflects the need for integration and collaboration across the system. It will have the ability to exercise its functions through place-based committees (while remaining accountable for them) and it will also be directly accountable for NHS spend and performance within the system.
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> The ICB will, as a minimum, include a chair, chief executive office, and representatives from NHS trusts and foundation trusts, general practice and local authorities. Beyond that, local areas will have the flexibility to determine any further representation in their area. ICBs will also need to ensure they have appropriate clinical advice when making decisions.[49]

Under clause 14, each ICB would have to publish its constitution, in accordance with schedule 2. Schedule 2 includes provisions about who can be a member of an ICB and other governance arrangements.

Some of the concerns around ICBs have centred on what their membership would be, and in particular the potential level of involvement by private healthcare companies. Several government amendments were made to the bill's provisions on ICB membership in schedule 2.

Edward Argar described ICBs as "critical for delivering the key aims of the legislation: reducing bureaucracy; supporting integration and collaboration; and improving accountability".[50] He explained it was never the Government's intention for independent providers to sit on ICBs.[51] The Government believed the bill's conflict-of-interest provisions already addressed this. Clause 14 (as numbered in the Lords version of the bill) would require each ICB to maintain a register of the interests of members of the ICB, its committees and sub-committees and employees. However, Mr Argar said the Government wanted to "put the matter even further beyond doubt" with amendment 25. This would add a requirement to schedule 2 that an ICB's constitution must prohibit a candidate from being appointed to an ICB if the person making the appointment considered it could "reasonably be regarded as undermining the independence of the health service because of

[49] Explanatory Notes, paras 38–40.
[50] HC *Hansard*, 22 November 2021, col 114.
[51] ibid, col 116.

the candidate's involvement with the private healthcare sector or otherwise".

Mr Argar said the Government expected this to prevent directors of private healthcare companies, significant stakeholders of private healthcare companies, lobbyists and "anyone with an obvious ideological interest that clearly runs counter to the NHS's independence" from sitting on the board of an ICB. Mr Argar argued that banning private company employees completely from the boards of ICBs, as suggested by some, would exclude people with "minor interests in public healthcare", such as GPs who also had a private practice.[52] At the same time, it might not exclude people who were unsuitable candidates to sit on an ICB because of their involvement in the private healthcare sector, although they were not an employee of a private healthcare company.[53] Mr Argar concluded that the Government's amendment would make "entirely clear […] that ICBs will not and cannot be controlled in any way by the private sector".[54]

Justin Madders, Shadow Minister for Health and Social Care, said Labour could not support amendment 25 because it added "unnecessary subjectivity" and did not go far enough.[55] He spoke to several Labour amendments that he said would "limit the possibility for influence by vested interests, especially those of the private, for-profit sector". In particular, amendment 78 would have prevented representatives of private providers of healthcare services, other than GPs with a contract for providing primary care in the area, from being appointed to NHS decision-making boards, ICBs or any place-based committee or sub-committee of the boards.

Amendment 25 was agreed to without division.[56] Amendment 78 was defeated on division by 300 votes to 192, a majority of 108.[57]

Other government amendments to the bill's provisions on ICBs were agreed without division as follows:

- Clarifying that the constitution of an ICB may provide for more than one member to be nominated to the board by NHS trusts/foundation trusts, primary medical service providers or local authorities.[58] Previously schedule 2 specified that the ICB must include one member nominated by each of those groups.

[52] HC *Hansard*, 22 November 2021, col 117.
[53] ibid, col 118.
[54] ibid, col 119.
[55] ibid, col 121.
[56] ibid, col 161.
[57] ibid, col 162.
[58] ibid, col 115 (amendments 26 to 28).

- Applying the Network and Information Systems Regulations 2018 to ICBs. Edward Argar said this would require ICBs to protect their network and information systems by managing risks to ensure service availability and prevent patient harm.[59]

Virginity testing

A package of government amendments concerning virginity testing was agreed to without division. These amendments would make it an offence in England and Wales, Scotland, and Northern Ireland to carry out virginity testing, to offer to carry out virginity testing, or to aid or abet someone to carry out virginity testing in the UK or on UK nationals overseas. Virginity testing is defined as "the examination of female genitalia, with or without consent, for the purpose (or purported purpose) of determining virginity".[60] The Royal College of Obstetricians and Gynaecologists has stated that such an examination has no scientific merit and there is no known examination that can prove a history of vaginal intercourse.[61]

The new provisions are now included in part 5 and schedule 16 of the bill as introduced in the House of Lords. The Government's amendments followed efforts by the Opposition to introduce amendments at committee stage prohibiting virginity testing and hymenoplasty.[62]

Edward Argar said that legislating for these offences was a "profoundly important step forward in helping to tackling the damaging myths concerning the so-called purity of women's sexuality".[63] He said the maximum penalties for each offence—five years' imprisonment and/or an unlimited fine—reflected the long-term physical and psychological damage the practice of virginity testing could cause. Speaking for the Opposition, Justin Madders agreed that "this horrendous so-called procedure has absolutely no basis in science: instead, it is based entirely in misogyny".[64]

Richard Holden (Conservative MP for North West Durham), who had led a campaign on this issue and tabled his own amendments at report stage, argued it was "vital" that banning both virginity testing and hymenoplasty went hand in hand.[65] Hymenoplasty is a procedure undertaken to reconstruct a hymen, sometimes advertised as 'virginity surgery'.[66] The Royal

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[59] HC *Hansard*, 22 November 2021, col 114 (amendment 30).
[60] Clauses 122(2), 126(2) and 130(2).
[61] Royal College of Obstetricians and Gynaecologists, *RCOG Position Statement: Virginity Testing and Hymenoplasty*, August 2021.
[62] See: House of Commons Library, *Health and Care Bill: Committee Stage Report*, 18 November 2021, p 50.
[63] HC *Hansard*, 23 November 2021, col 206.
[64] ibid, col 218.
[65] ibid, col 245.
[66] Royal College of Obstetricians and Gynaecologists, *RCOG Position Statement: Virginity Testing and Hymenoplasty*, August 2021.

College of Obstetricians and Gynaecologists states that there is no clinical benefit to hymenoplasty, although it states that "in some very limited circumstances, there are procedures that are clinically necessary that could be construed as a 'hymen repair'" that should not be defined as hymenoplasty.

The minister explained that the Government had established an independent expert panel to explore the clinical, legal and ethical aspects of the procedure.[67] Mr Argar said the Government would carefully consider the panel's views before making a firm decision whether to ban hymenoplasty. The panel is due to report before Christmas 2021. Mr Holden said he hoped the Government would bring forward amendments on hymenoplasty when the bill reached the Lords.[68]

Devolved administrations

Edward Argar said the final group of government amendments had been negotiated with the devolved administrations to address concerns they had raised about some provisions in the bill.[69]

Clause 76 (as numbered in the Commons version of the bill) would have allowed ministers to make regulations allowing further exemptions to the obligation to reimburse pharmacies under the standard NHS arrangements when centrally stocked products have been supplied free of charge to community pharmacies. New clause 62 replaced this clause with a new clause that made corresponding provision for Wales, as well as England. Mr Argar said the new exemptions were limited to vaccinations, immunisations and products used for the prevention or treatment of disease in a pandemic.[70] This clause now appears as clause 135 in the bill.

Other amendments clarified aspects of clause 87 (medicine information systems) and clause 136 (international healthcare arrangements) in relation to Wales.

2.2.2 Backbench amendments made to the bill

The Government accepted three Conservative backbench amendments.[71] These were all made to the bill without division.

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[67] HC *Hansard*, 23 November 2021, col 207.
[68] ibid, col 245.
[69] ibid, col 278.
[70] ibid, col 279.
[71] HC *Hansard*, 22 November 2021, cols 127 and 141.

Priorities for the CQC when assessing ICBs

Amendment 114, tabled by Jeremy Hunt, changed what is now clause 26 to ensure that the secretary of state would have to include priorities relating to leadership, the integration of services and the quality and safety of services when setting priorities for the CQC in relation to its assessments of ICBs. Mr Hunt said the amendment would ensure that "whatever pressure NHS managers were under, they were always focused on safety and quality of care".[72]

Addressing the needs of victims of abuse

Amendment 102 tabled by Maria Miller (Conservative MP for Basingstoke) amended what is now clause 20 to require the joint forward plan for an ICB and its partners to set out any steps it proposes to take to address the needs of victims of abuse (including domestic and sexual abuse, whether of children or adults).

Cancer outcome targets

New clause 19 tabled by John Baron (Conservative MP for Basildon and Billericay) would require the secretary of state to include objectives on cancer outcome targets in the NHS mandate. These objectives would have priority over any other objectives relating to cancer treatment. Mr Baron argued there was often too much focus on 'process targets', for example that patients should not wait more than 62 days from referral for a suspected cancer to treatment, particularly where funding was attached to process targets.[73] He argued that 'outcome targets', such as improving the one-year or five-year survival rate for cancer, were what really mattered to patients. He suggested outcome targets would give healthcare professionals more flexibility to design their own solutions, such as running wider screening programmes and establishing greater diagnostic capabilities within primary care. He said they would also better align NHS priorities with patient needs by "placing improved outcomes—that is, survival rates—at the heart of the NHS".[74]

Mr Baron suggested that if the Government adopted his new clause, there would be time when the bill reached the Lords to assess its impact and amend it further if necessary.[75] Edward Argar said the Government was content to accept the new clause and would work with Mr Baron to explore ahead of the Lords stages of the bill whether it could give rise to any

[72] HC *Hansard*, 22 November 2021, col 126.
[73] HC *Hansard*, 23 November 2021, col 285.
[74] ibid, col 284.
[75] ibid, col 286.

unintended consequences.[76] The new clause is included as clause 4 in the bill introduced in the Lords.

3. What other issues were raised?

Apart from these three Conservative backbench amendments, no other non-government amendments were made to the bill at report stage. Eight amendments were pushed to a division; all were defeated. Some of these sought to change provisions that are already in the bill, on NHS procurement regulations, the membership of ICBs, health and social care workforce planning, the secretary of state's powers over the reconfiguration of NHS services, and requiring devolved consent for the use of some powers in the bill. Others sought to address issues not covered by the bill, such as regulating e-cigarettes, addressing alcohol harms and protecting the title of 'nurse'.

E-cigarette packaging and branding (NC4)

Mary Kelly Foy (Labour MP for City of Durham) moved new clause 4, which would have given powers to the secretary of state to put health warnings on e-cigarette packaging and prohibit branding on packaging that would make e-cigarettes attractive to children.[77] She said her aim was to prevent young people from starting to smoke. Edward Argar, Minister for Health, said the Government was committed to ensuring the regulatory framework continued to protect young people and non-smokers.[78] He argued the current regime remained appropriate to do so and already had the powers in place to make changes where required. NC4 was defeated by 297 votes to 230, a majority of 67.[79]

Alcohol treatment providers (NC16)

Alex Norris, Shadow Minister for Health and Social Care, moved new clause 16, which would have required the secretary of state to make an annual report to Parliament on how the funding received by alcohol treatment providers had supported their work to improve treatment and reduce harm.[80] Mr Norris argued that the Government was not meetings its responsibility to tackle alcohol harm "with the requisite financial commitment".[81] Edward Argar said the Government already had a "strong regime" to tackle the consequences of alcohol misuse, and did not feel the bill was the place to legislate further on the issue.[82] NC16 was defeated by

[76] HC *Hansard*, 23 November 2021, col 294.
[77] HC *Hansard*, 22 November 2021, col 55.
[78] ibid, col 88.
[79] ibid, col 89.
[80] ibid, col 93.
[81] ibid, col 63.
[82] ibid, col 86.

298 votes to 194, a majority of 104.[83]

Procurement regulations (amendment 72)

Clauses 70 and 71 of the bill would enable a new procurement regime to be developed for the NHS and public health procurement. The Government argues this would reduce bureaucracy and "reduce the need for competitive tendering where it adds no value".[84]

The explanatory notes state:

> The procurement reforms within the bill will enable the removal of the current procurement rules which apply for NHS and public health service commissioners when arranging clinical healthcare services, eg hospital or community services. The bill provides a power to create a separate procurement regime for these 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. The bill provisions also repeal section 75 of the 2012 [Health and Social Care] Act and the National Health Service (Procurement, Patient, Choice and Competition) (No 2) Regulations 2013.
>
> […] These reforms will only apply to the procurement of clinical healthcare services, and 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. 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 services 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.[85]

Clause 70 provides that the regulations establishing a new procurement regime may make provision for the purposes of ensuring transparency or fairness in relation to procurement, ensuring that compliance can be verified, or managing conflicts of interest. However, it is not an obligation for the regulations to cover these matters.

There have been concerns around these provisions even from those who welcome the end of compulsory competitive tendering. For instance,

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[83] HC *Hansard*, 22 November 2021, col 93.
[84] Explanatory Notes, para 115.
[85] ibid, paras 113 and 116.

Richard Burgon (Labour MP for Leeds East), argued at report stage:

> There is a sleight of hand going on with this bill. It is true that under the bill NHS bodies will no longer have to put services out to competitive tender to the private sector. Such tending to the private sector was made a requirement under section 75 of the coalition Government's Health and Social Care Act 2012. It was a shameful act and its scrapping has long been demanded by those opposed to privatisation of our national health service. However, the change in this bill does not reverse privatisation, because without making the NHS the default provider, that simply means that contracts can not only still go to private healthcare corporations but can do so without other bids having to have been considered.[86]

Labour proposed an amendment to the bill's provisions on procurement regulations. It would have introduced mandatory transparency requirements for awarding contracts with an annual value over £5m to non-NHS bodies. Justin Madders said this would "reintroduce some safeguards into how our money is spent".[87] He said Labour's position was that the NHS should be the default provider of clinical services and going outside the NHS should be "a last resort and never a permanent solution". He argued that the use of private sector capacity during the Covid emergency had been "a farcical failure" which had "highlighted the need for greater transparency and greater capacity in the NHS". The amendment was defeated by 302 votes to 195, a majority of 107.[88]

Integrated care boards (amendment 78)

As mentioned above in section 2.2.1, a Labour amendment seeking to prevent representatives of private healthcare providers from sitting on NHS decision-making boards, ICBs or any place-based committees or sub-committees of the boards was defeated on division by 300 votes to 192, a majority of 108.[89]

Protecting the title 'nurse' (NC 12)

Dawn Butler (Labour MP for Brent Central) moved new clause 12 which sought to make it an offence to practise or carry on business using the title 'nurse' without being registered with the Nursing and Midwifery Council as a registered nurse or specialist community public health nurse. Only people who are registered with a regulator can use a protected title, and it is an

[86] HC *Hansard*, 22 November 2021, col 146.
[87] ibid, col 122.
[88] ibid, col 158.
[89] ibid, col 162.

offence for a person to use a title they are not legally permitted to use.[90] 'Registered nurse' and 'specialist community public health nurse' are protected titles, but 'nurse' is not.[91]

Dawn Butler said it was "shocking that anybody can call themselves a nurse, whether or not they have any qualifications".[92] She pointed to cases where people had been struck off the nursing register but continued to use the title 'nurse' while publicly delivering misleading information about the pandemic.[93] She said her amendment was supported by more than 70 nursing organisations. Speaking for the Labour Party, Justin Madders agreed it was time to put an end to misuse of the title.[94]

Edward Argar acknowledged there was benefit in providing reassurance and clarity for patients and professionals.[95] However, he said that protecting a title was only one part of a wider regulatory system. He also argued consideration would have to be given to the use of the title nurse by multiple professions including dental nurses, school nurses and veterinary nurses. Mr Argar said the Government could not support the amendment as drafted, but he would continue to reflect on the intent behind it. The Government has been exploring the use of protected titles more widely as part of a review of the regulation of healthcare professionals.[96]

New clause 12 was defeated by 304 votes to 240, a majority of 64.[97]

Workforce planning (amendment 10)

Clause 35 (as numbered in the Lords version of the bill) would require the secretary of state to publish a report at least once every five years describing the system in place for assessing and meeting the workforce needs of the health service in England. The Government maintains that the report will "provide clarity and transparency as to how the workforce planning and supply system operates, by describing the […] roles of relevant national bodies—including DHSC, HEE [Health Education England] and NHS England, ICBs and individual employers—and how they work together in practice".[98] However, the bill will not set workforce targets.

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[90] Department of Health and Social Care, *Regulating Healthcare Professionals, Protecting the Public*, March 2021, p 44.
[91] Nursing and Midwifery Council, *Modernising Midwifery Regulation: Protected Title, Function and Midwifery Scope of Practice*, 2016, p 2.
[92] HC *Hansard*, 23 November 2021, col 230.
[93] ibid, col 231.
[94] ibid, col 218.
[95] ibid, col 248.
[96] Department of Health and Social Care, *Regulating Healthcare Professionals, Protecting the Public*, March 2021.
[97] HC *Hansard*, 23 November 2021, col 255.
[98] Explanatory Notes, para 57.

Jeremy Hunt moved amendment 10 which would have required this report to be published at least every two years, and to include independently verified assessments of the current and future health, social care and public health workforce supply, and the workforce needed to meet projected health and care needs. NHS England and Health Education England would have had to assist in preparing the report, in consultation with employers, providers, trade unions, royal colleges and universities.

Speaking to the amendment, Mr Hunt said the Government had been "generous" in the amount of extra funding it had allocated to deal with current pressures on the NHS.[99] However, he argued that "extra money without extra workforce will not solve the problems" of lack of staff. He said the problem was "acute", with the royal colleges reporting current shortages of many thousands of doctors, nurses and other allied health professionals.[100] He argued his amendment would lead to more doctors and nurses being trained, which would save the NHS money in the long run as less would need to be spent on locums. He argued that more long-term planning was needed, in contrast "with some of the short-termism that we have seen recently".[101] He said he had the support of 50 organisations, including all the royal colleges and the British Medical Association (BMA).[102]

Justin Madders said Labour supported the amendment.[103] He welcomed its explicit recognition of the need to consult with the workforce through trade unions, and its inclusion of both health and social care.[104] He argued it was necessary to "compel a regular report and review of demand" and to use this as "a crucial lever for the change we need to see". However, he suggested that the amendment was weaker than a similar one tabled by Labour as it did not require the Government to set out how it would deliver and fund a plan to address any workforce gaps identified in the review process.

Edward Argar said the Government was already doing "substantial work" on workforce planning.[105] It had already committed to publishing a plan for elective recovery and a white paper on social care that would include reforms to improve recruitment and retention in the social care sector. He said the Department for Health and Social Care had commissioned Health Education England to develop a 15-year strategic framework for the health and social care workforce, looking at the key drivers of workforce supply and demand over the longer term. The Government anticipated this would be published in spring 2022. He said the recently announced merger of Health Education England and NHS England would bring together for the

[99] HC *Hansard*, 23 November 2021, col 221.
[100] ibid, col 222.
[101] ibid, col 223.
[102] ibid, col 224.
[103] ibid, col 213.
[104] ibid, col 216.
[105] ibid, col 208.

first time those responsible for planning services, for delivering services and for delivering the workforce, which would enable the framework to take a more integrated approach.

Amendment 10 was defeated by 280 votes to 219, a majority of 61.[106]

Some of the organisations that had backed Mr Hunt's amendment responded after the defeat. For instance, the BMA said the Government had "squandered this opportunity to demonstrate a commitment to safe staffing in the NHS". It viewed the bill as "woefully short of detail on workforce planning" at a time when there were over 93,000 overall staff vacancies in the NHS.[107] The Royal College of Physicians urged the House of Lords to "carefully consider the value and principles of this amendment" and take it up in the next stages of the bill.[108]

Secretary of state's powers over reconfiguration of services (amendment 70)

Labour moved an amendment to remove clause 39 (clause 40 in the Lords version of the bill). This clause gives the secretary of state discretionary powers to 'call in' reconfigurations, so they would be referred to the secretary of state rather than dealt with locally by NHS bodies. 'Reconfiguration' is the term used to describe the management of service change in the NHS that has an impact on patients, for instance closing several stroke units and replacing them with a single centralised unit.[109]

Justin Madders argued the clause "makes a mockery of the overall thrust of this bill, which is about encouraging local decision making".[110] He argued that decisions about reconfigurations should be left to clinicians or health economists, not the secretary of state, who could be "accused of favouring certain areas or decisions for political purposes".

Labour's amendment was defeated by 307 votes to 191, a majority of 116.[111]

Devolved consent (amendment 82)

Philippa Whitford, Scottish National Party spokesperson for health and social care, moved amendment 82, which would have required the secretary

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[106] HC *Hansard*, 23 November 2021, col 259.
[107] British Medical Association, 'The Government has squandered the opportunity to achieve safe staffing in NHS and patient care will suffer, warns BMA', 23 November 2021.
[108] Royal College of Physicians, 'RCP responds to report stage debate on amendment to strengthen workforce planning in the Health and Care Bill', 23 November 2021.
[109] Explanatory Notes, p 26.
[110] HC *Hansard*, 23 November 2021, col 280.
[111] ibid, col 296.

of state to obtain consent from the relevant devolved government before making regulations under the act in an area of devolved competence. She called on anyone who supported devolution in principle to support the amendment.[112] The amendment was defeated by 311 votes to 239, a majority of 72.[113]

4. What are political parties' views on the amended bill?

The Government and the Labour Party set out their views on the amended version of the bill at its third reading on 23 November 2021.[114] Sajid Javid, the Secretary of State for Health and Social Care, said the bill would provide colleagues in health and social care with the framework to help them work "as one to deliver for the benefit of their patients".[115] He said the principles that underpinned the bill, "embedding integration, cutting bureaucracy, boosting accountability" were important as the country recovered from the pandemic and learnt from it.

Mr Javid highlighted four key changes made to the bill in response to concerns raised.[116] Firstly, he said the Government had heard the desire of the House of Commons to rate and strengthen the safety and performance of the integrated care systems, and had introduced an amendment giving the CQC a role in reviewing ICSs.[117] Secondly, in response to concerns about the independence of ICBs, the Government had tabled an amendment to write into the constitution of ICBs the principle that nobody "with significant involvement or interests in private healthcare should be on an ICB". Thirdly, to respond in a "pragmatic way" to concerns about the impact of restrictions on advertising less healthy food and drink, the Government had introduced amendments to "ensure we do not unintentionally impact UK businesses when they advertise to overseas audiences". Fourthly, he said the bill "now reflects our commitment to end the crisis in social care and the lottery of how we all pay for it".

Mr Javid also gave a commitment to look at the issue of parity of esteem between mental and physical health.[118] This had been raised at report stage by Sir Charles Walker (Conservative MP for Broxbourne) and others, including Theresa May. Sir Charles tabled a series of amendments proposing taking general references to 'health' in the bill and changing them to 'physical and mental health'. None of these amendments was put to a formal decision. Edward Argar clarified at report stage that current references in the bill to

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[112] HC *Hansard*, 23 November 2021, col 282.
[113] ibid, col 305.
[114] ibid, cols 309–21.
[115] ibid, col 310.
[116] ibid, col 311.
[117] See: House of Commons Library, *Health and Care Bill: Committee Stage Report*, 18 November 2021, pp 18–19.
[118] HC *Hansard*, 23 November 2021, col 311.

illness or health were intended to cover both physical and mental health and the Government had taken the view it was not necessary to make that explicit.[119] Mr Argar had undertaken to meet Sir Charles and Mrs May to discuss the matter further before the Lords stages of the bill.

At third reading, Jonathan Ashworth, the then Shadow Secretary of State for Health and Social Care, acknowledged that Labour had welcomed some aspects of the bill.[120] He said it "scrape[d] some of the worst vestiges of the Lansley reorganisation [the Health and Social Care Act 2012] off the boots of the NHS", for example the compulsory competitive tendering of contracts. Labour also welcomed some of the public health provisions, such as those on advertising, but regretted that the bill did not go further on smoking cessation and alcohol.

However, Mr Ashworth said Labour could not support the bill overall. He argued that "an extensive reorganisation of the national health service at a time when we are still in a pandemic" was "the wrong bill at the wrong time". He argued the Government should be prioritising waiting lists, the backlog of referrals for mental health treatment, and pressures on A&E, ambulance services and general practice.

He expressed his hope that the House of Lords would return to the new clause on the social care cap and return the bill so the Commons could look at it again.[121] He also said the amended provisions on the role of the private sector in ICBs were not strong enough and were something Labour wanted to look at again. He also criticised the bill for allowing the Government to award contracts to the private sector without proper scrutiny. For these reasons, he said Labour could not support the bill.

The bill was given its third reading by 294 votes to 244, a majority of 50.[122]

The Liberal Democrats have argued that the bill "pays lip service only" to social care and does not properly integrate health and social care.[123] They have highlighted that the bill does not mention unpaid carers. The party has said it will keep pushing for carers to be included in the bill as it goes through the Lords.[124]

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[119] HC *Hansard*, 23 November 2021, col 294.
[120] ibid, col 313.
[121] ibid, col 314.
[122] ibid, col 317.
[123] HC *Hansard*, 22 November 2021, col 139.
[124] Liberal Democrats, 'Carers Rights Day', 25 November 2021.

5. What have others said about the bill?

Various organisations commented ahead of the bill's final stages in the Commons about their view of the bill and ways they would like to see it amended.

NHS Providers, the organisation that represents NHS trusts, has welcomed the direction of travel set out in the bill, which it sees as "aim[ing] to deliver closer collaboration and integration across the health and social care sector".[125] However, it is concerned that "provisions in the bill open up the possibility of political interference in the health service by drawing significant powers of intervention and direction to the secretary of state". It believes the new powers to allow the secretary of state to intervene in local service reconfigurations "risk undermining local accountability in the NHS".

In relation to private provider membership of integrated care boards (ICBs) and the amendments tabled at report stage, NHS Providers questioned the premise that "private providers will not be given a seat at the table on ICBs". It sought to make the point that private providers played an important, but not growing, role in the NHS. The organisation highlighted that "NHS trust leaders are clear that private providers are an important partner in local health and care systems". It said there had not been a significant increase in the share of the NHS's total revenue budget going to private providers (around 7%) since market-based approaches and tendering were extended in the Health and Social Care Act 2012. It sought assurances that amendments to the governance arrangements of ICBs would not stop GP practices, community interest companies and the voluntary, community and social enterprise sector from sitting on ICB boards.

NHS Providers believes that Jeremy Hunt's amendment giving the secretary of state powers to set objectives for the CQC's assessments of ICBs "could risk creating a regulatory system that is overly focused on national priorities rather than local population needs". However, it supports Mr Hunt's defeated amendment on workforce planning, arguing that the workforce reporting duty set out in the bill needs to be considerably strengthened.

NHS Providers expressed its support for the creation of the Health Services Statutory Investigations Body (HSSIB) as an independent statutory entity. However, it set out its concerns that "aspects of the bill as currently drafted are liable to weaken the boundaries of safe space and the independence of HSSIB".

The BMA supports some aspects of the bill, such as the removal of competitive tendering, but it believes the bill "is likely to do more harm than

[125] NHS Providers, *The Health and Care Bill 2021: House of Commons Report Stage, 22 and 23November 2021*, November 2021.

good".[126] It opposes undertaking "the biggest reorganisation in a decade" while the NHS is still "under huge pressure from the pandemic".[127] As well as supporting Jeremy Hunt's defeated amendment on workforce planning, the BMA called for amendments to the bill in several other areas. Although it supports the removal of competitive tendering, the BMA is concerned that contracts could be awarded to private sector providers without proper scrutiny or transparency. It said this would be "wasteful and destabilising outsourcing". It has called for the NHS to be the default option for NHS contracts, and for there to be safeguards in place to ensure the private sector is only used "when absolutely necessary", with "adequate scrutiny and transparency" in place.

The BMA does not believe the Government's amendment on private provider membership of ICBs goes far enough to "rule out the threat of private providers wielding influence over commissioning decisions or the wider ICS [integrated care system] strategy". It called for amendments to rule out corporate health providers as members of integrated care boards and integrated care partnerships. Furthermore, the BMA does not accept that the Government's amendments clarifying that ICBs can appoint more than one member nominated by primary care, NHS trusts and local authorities were sufficient to ensure clinical leadership and representation.

The BMA has also called for greater accountability in relation to the secretary of state's powers, suggesting that "unchecked, these wide-ranging powers could result in undue political influence in NHS decision-making". It suggested there should be transparency and consultation requirements attached to the secretary of state's powers over service reconfigurations and that revisions to the NHS mandate should be subject to the affirmative procedure in Parliament.

Like the BMA, the union Unison supports the bill's scrapping of the existing procurement system and the competition enforcement powers of health regulators.[128] Equally, it is concerned about the greater powers being given to the secretary of state and the involvement of private companies in integrated care partnerships and would like to see the NHS as the default provider of services. Unison highlighted concerns about the impact on the least well off of the changes to accounting for means-tested support towards the social care cap. It said it would continue to campaign against this as the bill goes through the House of Lords.

The Local Government Association (LGA) has given its broad support to the bill's focus on greater integration between NHS organisations and between

[126] British Medical Association, 'The Health and Care Bill', 22 November 2021.
[127] British Medical Association, *Health and Care Bill: House of Commons, Report Stage, 22–23 November*, November 2021.
[128] Unison, 'The Health and Care Bill: All you need to know', 26 November 2021.

the NHS and local government.[129] It noted that statutory guidance would be needed to accompany the legislation to help local systems make their own arrangements for joining up services. The LGA identified the secretary of state's powers over reconfiguration as an area of concern, suggesting this change could "undermine existing local authority health overview and scrutiny powers and corrode local accountability".

The LGA also alluded to the impact of financial pressures on local authorities' ability to deliver some of the bill's outcomes:

- We support the repeal of legislation related to delayed discharges. This paves the way for the continuation of discharge arrangements which have worked well during the pandemic. The emerging evidence is that going home straight from hospital is what people want. However, the policy is not fully implemented by the NHS and local government because of the ongoing pressures of Covid and the uncertainty over funding. We also need a flexible joint workforce working across health and social care to ensure that people get holistic and person-centred support to regain their independence.
- The provisions for assuring local authorities' adult social care functions set out a new role for the CQC and the secretary of state in the review and performance assessment of councils. We are working closely with the CQC, DHSC and other partners to ensure the assurance process is proportionate, includes a clear and continuous role for existing sector-led improvement work, and takes account of the significant financial pressures facing adult social care in their assessments.

In its assessment of the bill, the King's Fund think tank also highlighted concerns about the secretary of state's powers and a lack of workforce planning, as well as a widening of health inequalities as a result of the pandemic.[130] It called for the bill to be amended to address these issues:

- Extensive new powers for the secretary of state to intervene in local service reconfigurations bring the risk of a decision-making log jam and political expediency trumping clinical judgement. We believe these clauses should be removed from the bill.
- Parliament should seek further clarification about the scope of the new powers conferred on the secretary of state by the bill, in particular those to direct NHS England, and ensure that there is adequate scrutiny of their use.

[129] Local Government Association, 'Health and Care Bill, Report Stage, House of Commons, 22 November 2021', 19 November 2021.
[130] The King's Fund, *Health and Care Bill: House of Commons Report Stage and Third Reading*, 16 November 2021.

- The measures in the bill to address chronic staff shortages remain weak and the workforce crisis has become a blind spot for the government. A new duty should be added to the bill, requiring the regular publication of projections of the current and future workforce required to deliver care to the population in England.
- The Covid-19 pandemic has exposed deep and widening health inequalities. To ensure addressing this challenge is given sufficient priority, the new 'triple aim,' which is designed to create a common purpose across the NHS, should be amended to incorporate reducing health inequalities.

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