Joint Statement on the Health & Care Bill to unite campaigners, trade unions and opposition parties

The Health and Care Bill tabled in early July is deeply flawed and cannot be supported. It says virtually nothing about the key issue of the workforce, barely mentions social care, and does not address any of the major problems confronting our health and care systems after a decade of austerity funding and decades of privatisation and fragmentation into markets and outsourced contracts. It will create disruption for years on end at a time the NHS needs to focus on recovery after Covid.

We welcome the decision of Labour and opposition MPs to oppose the Bill at second reading and to continue to fight it through amendments in the Commons and the Lords that tackle the main negative elements of the Bill.

Amendments that succeed can limit any damage that might be done by an unamended Bill, while the arguments used against amendments that do not succeed can help us highlight the implications and the motivation behind the Bill.

While many of us have additional concerns about the way the Bill would be used and its wider consequences in the light of existing and proposed NHS England policies, amendments need to distinguish between what is in the Bill on the one hand, and issues that may have arisen in, or been thought to underly previous NHS England proposals and the White Paper.

Key issues that we oppose in the Bill and on which we support amendments are:

- **Competition, procurement and privatisation**
- **Duties of the Secretary of State (SoS)**
- **Strengthening local accountability**
- **Foundation Trusts**
- **Payment scheme**

<u>Competition Procurement and Privatisation</u>

The bill removes section 75 of Andrew Lansley's Health and Social Care Act 2012 and associated regulations, which trade unions, campaigners, Labour and opposition parties opposed and fought to defeat. This partial repeal in itself does not abandon the market system entrenched by Lansley. Nor does it prevent or reverse privatisation:

- It doesn't establish the NHS as the default provider when existing contracts come to an end.
- Nor does it prevent competitive tendering, or the extension of "framework contracts," through which contracts can be awarded without competition or tender to private companies (or other providers) from a pre-approved list. The Bill's repeal of the 2015 Public Contracts Regulations would leave little or no protection against more crony contracts awarded without proper oversight.
- Nothing in the Bill prevents more trusts – or ICBs – setting up subsidiary companies to dodge taxes, evade scrutiny or undermine terms and conditions of staff.
- Even the partial repeal of Section 75 does not extend to important non-clinical services which should be delivered by NHS staff – cleaners, porters, caterers and others. These services should not be fair game for more outsourcing.

The Provider Selection Regime proposed by NHS England has also come under considerable criticism. Although this is not part of the Bill it is the one that will shape the resulting regulations that will apply unless challenged. That's why one key amendment must require that no contract can be

awarded to a private company unless there has been a process as least as thorough as the Public Contracts Regulations that currently apply.

Amendments will be Seeking tighter rules to prevent cronyism and break out of the excessive secrecy of the current system by making all NHS business and decision-making fully open and transparent, with full declaration of conflicts of interest, and no commercial confidentiality exceptions – as well as a tough regime requiring ICBs to justify the award of any actual contracts outside NHS.

Amendments will demand that all private contracts must be subject to strong contract management, and with no competition on price.

Eliminating corporatisation of primary care also requires amendments to prevent the abuse of APMS contracts. As these expire, GPs should be brought back onto standard contracts, closing a gateway through which private firms like Virgin and Centene have been able to buy in to primary care.

Duties of SoS

Those who campaigned against the Lansley Bill will be in favour of the Secretary of State being held directly responsible for the NHS, as was clear before 2012. But not all of the many new powers proposed in the Bill are appropriate, and there must be proper parliamentary oversight of their use.

Making every NHS organisation inform the Secretary of State every time they think about changing a service would create a bureaucratic nightmare, and new powers for him to intervene on reconfigurations runs the risk of politically-driven decisions being imposed on local services.

Nor are the new Secretary of State powers coupled with the restoration of the pre-2012 duties of the Secretary of State. An amendment will be moved that would reverse this aspect of the 2012 Act, and return to the original wording. Given the new structure of the NHS, the same duties should also apply to NHS England and ICBs, through which the SoS carries out these duties

Loss of local accountability

The Bill follows five years of top-down pressure to merge Clinical Commissioning Groups (CCGs) created by the Lansley Act, and it abolishes the CCGs that remain. It will leave England with just 42 ICBs – the fewest "local" bodies since NHS reforms began almost 50 years ago.

Although there is a mandatory seat on each ICB for local government, the reduced number of decision-making bodies significantly reduces local accountability and local voice on future policy, while extending central powers of the Secretary of State and NHS England, including a new power to intervene and initiate a reconfiguration of services – which must be opposed.

The Bill would allow chairs of the 42 ICBs to be appointed by NHS England subject to approval by the Secretary of State – but only allow their removal if the Secretary of State agrees. This means ICB chairs, who under the Bill would have considerable powers, would be accountable only upwards, but not at all to local councils, communities and constituencies. Instead amendments are needed to require ICB chairs to be ELECTED in a system analogous to Mayors or Police and Crime Commissioners.

All other ICB non-executives would be appointed by the chair under the Bill, with no fair process respect for diversity, or independent overview.

The Bill gives no voice to patients on ICBs, but could potentially allow people associated with the interests of private companies to sit on ICBs and Integrated Care Partnerships. This threat of increased influence of private providers on NHS decision making must be explicitly ruled out.

The narrow composition of ICBs creates the danger that strong vested interests such as a large Foundation Trust could dominate – and services such as mental health or community health could be pushed to the side lines. Directors of Public Health are not core members of ICBs. The pledge in the NHS Constitution that staff and their representatives will be engaged and consulted over any proposed changes in services that affect them is ignored in the Bill.

The single local government seat on ICBs covering wide geographical areas would leave no real voice for local authorities at the "place" level. The Bill makes no reference to "place" and has no provisions to implement NHS England's repeated promises of delegation of decision-making to 'place' level. Instead each ICB would set its own constitution, opening up a new post code lottery of varying levels of local influence.

Amendments have already been tabled to toughen up requirements for all NHS bodies to meet in public, make arrangements for remote access, publish all the papers in good time, and seeking to prevent them from using any argument of commercial confidentiality to avoid providing information.

In line with the proposals from nine councils in Cheshire & Merseyside amendments are also required to ensure that each ICS should be based on the principle of "primacy of place", with all matters devolved to place-based decision-making, unless there is a compelling reason (agreed by the ICS Partnership Board) for aggregating responsibility at the ICS level.

Local access to the full range of NHS services should be guaranteed to all communities, and any change to local services must be subject to oversight by each council's Health Scrutiny function. Local authority powers to refer contested changes to the Secretary of State must be preserved.

The proposed Integrated Care Partnerships are being set up with little or no powers to influence the integration of care. Amendments can highlight the need for them to be able to challenge NHS decisions which do not accord with local wellbeing strategies, or which do not address local needs adequately, and put forward their own proposals.

Funding allocations to places and providers, and all major decisions over expenditure by ICBs should be transparent, fair, and subject to local democratic challenge by the ICP and local authorities. Meetings of the ICS Partnership Boards also need to be held in public, and webcast.

Discharge to assess

The Bill also proposes to change the law to remove the legal requirement to assess patients prior to discharge from hospital.

While some pilot schemes have deployed additional resources to facilitate "discharge to assess" – and of course there were specific reasons for suspending the law during the pandemic – the general picture outside hospitals is one of grossly inadequate community and primary care and social care services, raising a real risk in many areas of patients discharged in this way merely being dumped without support.

Amendments must require stringent safeguards before any such changes, and protect patient rights.

Trusts and Foundation Trusts

To enable proper integration of services, the whole of the market infrastructure should be removed. The Bill does remove the duty around promoting autonomy, curbs some of the "freedoms" of Foundation Trusts (FTs) and scraps what proved to be unachievable requirements of the 2012 Act for all NHS trusts to become foundation trusts.

But it leaves FTs outside of any "integration" process and not subject to direction by the ICBs or by NHS England. It also leaves intact the highly controversial 2012 Act provision for FTs to expand their private patient and non-NHS income up to half of the FT's total revenue without any proper scrutiny.

This is an obstacle to any integration of services, since some FTs would be free to go their own way and focus on non-NHS activity at a time when NHS resources are stretched to the maximum. Some FTs, like Oxford University and Royal Marsden are already doing so.

Amendments to the 2012 Act can highlight why FTs should be on equal status with NHS trusts (a level playing field), make them subject to direction in the same way, reimpose the cap on non-NHS income, and require both FTs and NHS Trusts to publish income AND EXPENDITURE details of any private patient activity – to expose the real cost to the NHS.

Payment scheme

A new NHS Payment scheme is proposed in the Bill to replace the current national tariff of prices for patient care with locally-negotiated prices – which poses the danger of a race to the bottom on quality of care and a revival of price-based competition.

The details of any new regime are wholly unclear and some restrictions should be put into the Bill to ensure a genuine move away from market-based mechanisms like payment by volume and back to block contracts based on nationally-decided costings. Competition based on price should not be permitted.

Workforce Planning

The Bill (Clause 33) proposes only a very weak duty as regards planning. ICBs must have a duty to plan to meet their workforce needs as a key part of any planning. All workforce plans must include recognition of nationally agreed Agenda for Change terms and conditions for all but the most senior NHS staff.

Professional regulation

New powers over professional regulation should not be given to the SOS unless the Bill imposes some stronger oversight by parliament and some test to apply as to the overall value of any change. These proposals are in Part 5 of the Bill, allowing more time for trade unions, professional bodies and campaigners to collaborate on a more substantial critique of the government proposals and lobby for appropriate amendments to address concerns over deregulation and the likely adverse impact on standards and patient care.

Other parts of the Bill

Some sundry additional sections of the Bill which do not directly relate to the proposals for Integrated Care Systems and how they should work will also need to be scrutinised and addressed, but agreement on these is not necessary as a basis for the main campaign to oppose the Bill and to highlight its many flaws through targeted amendments.

Campaigning will also continue on pay, terms and conditions and other potential issues and legitimate concerns relating to ICSs but not directly covered by the Bill.