HEALTH and CARE BILL BRIEFING

Bill will not end privatisation

The government's Health and Care Bill, now going through Parliament repeals a highly controversial section of the 2012 Health and Social Care Act – Section 75 – which requires services above an annual cost of £600,000 to be put out to competitive tender.

However the Bill does not stop privatisation. Section 75 itself has been increasingly widely ignored.

It's estimated that as few as 2 percent of clinical contracts go through a full competitive tendering process – and the Bill only relates to clinical contracts.

NHS England has devised numerous work-arounds to avoid competitive tendering, while still handing out large contracts to private companies.

These include use of 'framework contracts,' which establish lists of pre-approved providers who can be awarded contracts without any formal tender.

Recent plans for new networks to provide imaging services (MRI, CT, X-ray and ultrasound) could even see these key services owned and run by commercial companies.

Another framework contract, specifically designed to promote digital technology and new methods and models in Integrated Care Systems (ICSs), is the **Health Systems Support Framework,** which lists some 200 firms, at least 30 of them US-owned and prominent in the health insurance market.

They include Centene (now controlling dozens of GP surgeries and community services), Optum (owned by US health insurance firm UnitedHealth), IBM, and Palantir.

The Bill also repeals key parts of the 2015 Public Contracts Regulations, which limit the danger of even more of the now notorious 'crony contracts' that were awarded for PPE and other procurement with no competition, scrutiny or regulation during the peak of the Covid crisis. If this happens, the repeal of section 75 could be followed by even more privatisation.

What we want

We need legislation to end privatisation and reintegrate the NHS as a public service, publicly provided and accountable. But now we need to amend this Bill to:

- Extend the repeal of Section 75 to also end competitive tendering for **non-clinical services**
- Make the NHS the **default provider** when any contracts expire.
- Ban trusts and ICSs from establishing **"subco" companies** (whether to dodge tax, escape national pay agreements or avoid scrutiny).
- **Tight regulations on procurement** to prevent the award of contracts without competition or scrutiny.
- Make all contracts and Integrated Care Board (ICB) business subject to the Freedom of Information Act, with **no commercial confidentiality**.
- Ensure there is **no private sector involvement** on Integrated Care Boards (ICBs) or any decision-making bodies at local or ICB level.

Health Campaigns Together is a coalition of campaigns, trade unions and political organisations fighting to defend the NHS. We agree that the Health and Care Bill tabled in early July is deeply flawed and cannot be supported.

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

This leaflet sums up some of the key issues that have to be addressed.

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October 1 2021

HEALTH and CARE BILL BRIEFING

Endangering patient safety and quality of care

The Bill includes a proposal that could potentially put vulnerable patients at risk: Paragraph 78 would repeal the legislation that requires each patient's needs to be assessed before they are discharged from hospital.

While a few local pilot schemes around the country have deployed additional resources to facilitate a so-called "discharge to assess" schemes, the general picture outside hospitals is one of grossly inadequate community and primary care and social care services.

The National Audit Office warned back in 2017 that there was little or no evidence to support claims that "integrating" services – which will remain severely under-funded and under-staffed – would bring improved outcomes for patients. Four years later there still is no evidence.

Recent research by the Centre for Policy Studies on early Integrated Care Systems has found failures in most, and major problems in two of the biggest early ICSs – a sharp rise in delayed transfers of care in Greater Manchester, and an increase in emergency readmissions within 30 days of discharge in West Yorkshire.

The growing gaps in care and support therefore raise a real risk that if patients are discharged more swiftly from hospital they could, in many areas, merely be dumped without support – and wind up back in hospital.

With no consistency in local policies or allocation of resources, the Bill threatens a new 'postcode lottery' on the quality and safety of services for vulnerable patients.

It has no significant proposals to address the growing crisis in social care, and the recent measures to increase National Insurance payments will make little if any difference to an increasingly dysfunctional system.

If the clause repealing existing protection is not deleted, amendments to the Bill must require stringent safeguards are put in place before such changes are implemented in any area, and protect patient rights.

Despite the increasing risk to patient safety posed by lack of staff, the Bill itself has no proposals to fix workforce shortages, or even to require the Health Secretary to monitor staffing levels more frequently than 'at least every five years'.

Some Conservative MPs have already supported amendments on this, and the unions are calling for the Bill to require the publication of independent annual reports on workforce shortages and future staffing requirements, covering social care as well as the NHS.

Serious plans to increase NHS staffing will obviously also require significant increases in pay.

Paragraph 123 of the Bill would give the Secretary of State powers to abolish professional regulatory bodies and remove professions from regulation: this will inevitably stoke fears in the workforce about deregulation and greater reliance on less qualified, cheaper staff to replace professionals.

With these dangers to patient safety embodied in the Bill it is little consolation to find it also includes proposals for a new Health Services Safety Investigations Body to "conduct major safety investigations into the most serious risks to NHS patients in England."

Much better to invest in viable, effective systems now and avert the threats posed by lack of staff, under-funding, clapped out equipment and crumbling buildings than to allocate scarce resources to investigating after unsafe systems go tragically wrong.

What do we want?

- **Delete Paragraph 78**, and retain existing legal protection of vulnerable patients
- Amendments to require **independent annual reports on workforce shortages** and future staffing needs in health and social care
- **Delete Paragraph 123** and any changes which might lead towards deregulation and de-professionalisation of health care
- **A full review** of the evidence on the effectiveness of ICSs in improving patient care, and the resources required to enable systems to meet local needs.

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HEALTH and CARE BILL BRIEFING

Undermining any local accountability

The Bill seeks to entrench top-down control, and extend the central powers of the Health Secretary to alter your local health services.

It will leave just 42 bodies – so-called Integrated Care Boards (ICBs) taking key decisions on local services across the whole of England. Some are enormous: they range in size from 500,000 to 3.2 million population. 26 ICBs cover a million or more, and the largest covers a huge coast to coast area in the North of England.

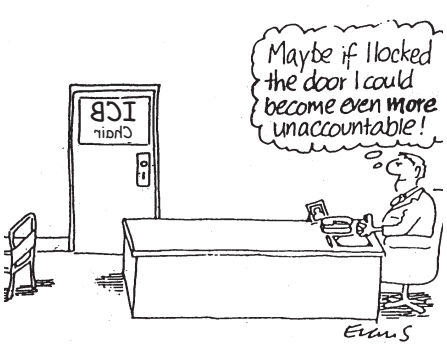
This is the lowest-ever number of "local" bodies in the NHS – leaving the weakest-ever local voice for patients, the public and health workers defending against cuts and pressing for services they need.

The chairs of these ICBs will be appointed centrally by NHS England – and answerable only to them. They can only be removed by agreement of the Health Secretary.

Chairs will have extensive powers, including involvement in choosing the ICB directors and chief executive.

The Bill doesn't require ICBs to include any representation of mental health, public health, patients, public or health workers.

Minister Edward Argar has committed to amend the wording to exclude the possibility of "individuals with significant interests in private healthcare" from sitting on ICBs – but he has not mentioned decision-making ICB committees, and the Bill specifically permits private sector involvement in the advisory Integrated Care Partnerships.



ICBs will decide what services should be available and what they choose to close to save money – because the reorganised NHS will be at least as short of funds as it has been for the past ten years.

As the Bill stands, all of these decisions about you will be taken without you or your elected councillors and MP having any say.

NHS England claims that there would be a 'principle of subsidiarity', meaning that 'place-based' decisions would be taken "as close to local communities as possible".

Local campaigns have been vital to defend threatened hospitals

However there is no mention of 'place' or 'subsidiarity' in the Bill, which would allow each ICB to decide its own constitution, leaving huge variation in accountability.

What do we want?

We need to fight for amendments to the Bill that will root decisions in local communities wherever possible, and give the public a say over the direction of their local services:

- Chairs of ICBs should be **elected locally**, like metro mayors or police and crime commissioners, not appointed from above.
- The Bill must require **place-based decision-making** at borough, unitary or county council level – unless there is a proven case for an ICS-wide strategy.
- There must be **no private sector involvement** in NHS decision-making bodies
- Existing council health oversight and scrutiny committees must **retain their powers**, including the right to refer contested plans for change to the Secretary of State.
- ICBs must include **representatives of patients, and health workers**, with all business done in public, and no 'commercial confidentiality'.
- Mental health, community health and public health professionals must be **given representation** on all ICBs.
- Foundation trusts, currently autonomous, must be made accountable to ICBs and NHS England, with the **same status as NHS trusts**, tough new limits imposed on their non-NHS income, and full accounts published on any private patient income.

For more information on Integrated Care Systems check out:
https://healthcampaignstogether.com/STPgeneralinfo.php
AFFILIATE to HCT: *https://healthcampaignstogether.com/joinus.php*

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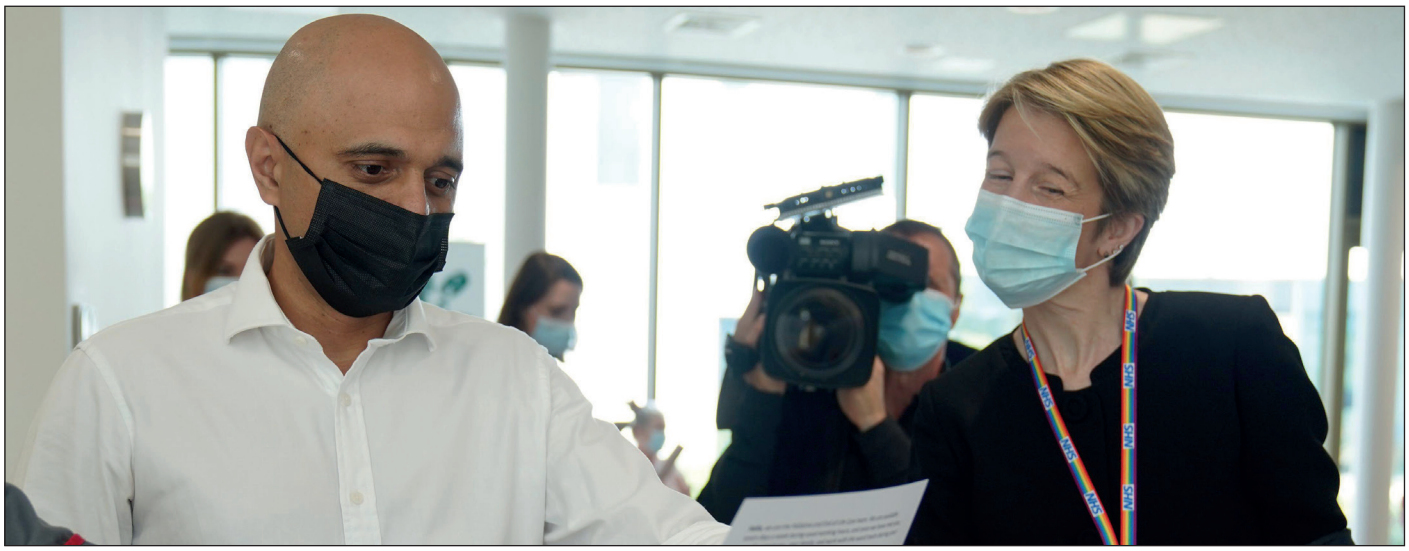

Health and Social Care Secretary Sajid Javid with new NHS England boss Amanda Pritchard: how much central power should they have?

Extend central duties, not powers

The Bill is a major reorganisation of the NHS. It will entrench top-down control, and extend the central powers of the Health and Social Care Secretary to alter your local health services.

The Bill would give 138 new powers to the Secretary of State, including controversial powers to intervene at any stage or initiate local plans to close or reorganise hospital services.

It also includes new powers to change the regulation of health professionals – which many fear could result in deregulation and a replacement of highly trained staff with less qualified – and cheaper – staff in the NHS workforce.

Back in 2011-12 campaigners fighting Andrew Lansley's Health and Social Care Bill demanded (without success) that the Secretary of State should remain directly responsible for the NHS as had been the case since 1948.

But while the new Bill now reverses some parts of the 2012 Act, not all of the many new central powers proposed in the Bill are appropriate: even Sajid Javid is reportedly considering dropping some of the proposals. For any that are agreed, 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: plans to reorganise stroke services in Kent, for example, have now been held up for 2 years waiting for ministers to decide whether they should go ahead.

But there are also fears that new powers for the Secretary of State to intervene at will on local plans to reconfigure hospital and other services runs the risk of politically-driven decisions being imposed on local services – while undermining the local powers of council health and scrutiny committees to stand up for local communities and refer controversial schemes to the Secretary of State.

Nor are the new powers coupled with the restoration of the pre-2012 duties of the Secretary of State to promote a universal and comprehensive health service.

An amendment is needed to reverse this aspect of the 2012 Act, and return to the original wording.

Moreover once Integrated Care Systems are in place, the same duties should also apply to them and to NHS England, to establish the principle of universal and comprehensive services throughout the NHS.

What we want

In place of more central powers, the Bill needs to be amended to ensure as much local power as possible is retained at the most local level.

- All matters should be devolved by ICBs to **place-based decision-making**, unless there is a compelling reason (agreed by the Integrated Care Partnerships) for decisions 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.
- Integrated Care Partnerships need to be **empowered to challenge ICB plans** or decisions 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.
- Meetings of the Integrated Care Partnerships also need to be **held in public**, and webcast.

For printed copies of this leaflet contact Health Campaigns Together at *www.healthcampaignstogether.com* or *healthcampaignstogether@gmail.com*
AFFILIATE to HCT: *https://healthcampaignstogether.com/joinus.php*

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