**https://publications.parliament.uk/pa/cm5802/cmpublic/HealthCare/memo/HCB26.htm**

**Written evidence opposing the Health and Care Bill, submitted to the Public Bill Committee by John Puntis co-chair of Keep Our NHS Public**, a national campaigning organisation seeking to maintain a publicly funded and provided universal healthcare system across the UK.

**Executive Summary**

This Bill will be highly damaging to the NHS as a national health service based on social solidarity. It will:

* fragment the NHS into 42 Integrated Care Systems (ICSs or ‘systems’) each containing an Integrated Care Board (ICB) (‘body corporate’) and associated ‘Partners’ and, by funding each system separately with its own Whole Population Annual Payment (WPAP)[[1]](#footnote-1), remove universal pooling of risk to the detriment of the poorest in society;
* enable the deregulation of procurement and so increase the potential for abuse in the giving of contracts, and in the reduction of social and environmental protections and rights for workers;
* introduce new concepts of ‘core’ and ‘key’ services to the systems - the reason for this terminology, similar to that used by US Health Maintenance Organisations, is unclear;
* remove the duty for the systems to provide secondary medical services and then, pushed by imposed funding limits, the systems can attempt to contain costs by developing ‘new models of care’ to replace the need for secondary care referral, and ration or deny other specific types of secondary elective care[[2]](#footnote-2),[[3]](#footnote-3) deemed either to be unnecessary or of lesser ‘value’, forcing people to pay for this care and creating a ‘two tier’ service;
* develop an infrastructure run by ICBs that, as well as enabling the inclusion of private companies, will reduce the representation and powers of Local Authorities (LAs) while committing them to the strict capitated financial regime, and reduce their power to influence reconfigurations of local NHS services;
* increase the use of digital technology in place of clinical judgement while deregulating the professions, to create a workforce which is ‘mobile’, ‘flexible’ and ‘agile’ for the sake of cost efficiency, so reducing the benefits of team work and the continuity and quality of relationships with patients;
* create a dependence on multiple transnational corporations to drive the creation of vast health and social care data sets - an invaluable research and planning resource but one that will be open to commercial exploitation;
* from the development of systems and data banks through to care management and provision, increase opportunities for private corporate profit making while NHS services remain underfunded.

**Fragmenting the National NHS and controlling system budgets**

1. The Bill provides statutory authority for 42 Integrated Care Systems (ICSs), modelled on Accountable Care[[4]](#footnote-4) specifically designed to reduce state expenditure on healthcare. Each ICS will be funded by its own Whole Population Annual Payment, with a legal duty placed on ICBs and eventually all their associated Partners, not to overspend their own and the system revenue and capital budgets[[5]](#footnote-5).
2. A key aim is to replace the national tariff system in which treatments have a fixed price for all patients, and replace it with a Payment Scheme. This may make different provision for the same service depending on local circumstances, areas, types of provider, other factors related to provision or arrangements for the service, different populations, and the range of services provided.[[6]](#footnote-6) Each ICS will have different costs, and disparities between ICSs are likely to develop. Among our concerns is the possibility that, in this context, the national scheme for staff pay, terms and conditions will be undermined – especially in the situation where there are strong pressures to cut costs. One outcome could be that staff migrate from poorly funded areas. Explanatory Note EN 27 makes it explicit that the private sector can influence the details of the payment scheme rules of how commissioners establish prices to pay providers.[[7]](#footnote-7)

**Deregulation of Procurement**

1. The Bill proposes repealing Section 75 of the Health & Social Care Act 2012; revoking the NHS (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013, and reducing the Competition and Markets Authority’s (CMA) competition duties (EN121-122). It provides a power to create a separate procurement regime for clinical services, and remove the procurement of health care services from the scope of the Public Contracts Regulations (PCR) 2015 (EN-114). The power provides for mixed procurements in the regime,[[8]](#footnote-8) so non-clinical services can be exempted from PCR 2015 if they are bundled with clinical services.
2. The removal from PCR 2015 will deregulate the market with the loss of the labour and environmental protections that enable contracting authorities to incorporate social, ethical and environmental aspects in their contract conditions and award criteria. These protections include specificrules to manage abnormally low tenders, and suppliers who have previously violated certain social, labour[[9]](#footnote-9) and environmental laws. There is strong evidence that all NHSE’s ‘integrated care’ ambitions could be achieved without removal from PCR 2015 and loss of its protections.[[10]](#footnote-10) However, as PCR 2015 restricts procurement without tendering to our public services[[11]](#footnote-11), deregulation is only specifically required if there is a wish to give contracts to private providers without tendering.
3. Clause 68 of the Bill provides for new regulations on procurement[[12]](#footnote-12) under which private provider companies may be able to extend their contracts or even be awarded new contracts without competition. This, along with less opportunity for contracts to be contested or scrutinised (only 4-6 weeks from announcement of intention to completion) and with contest only being allowed based on issues with the stated regime criteria[[13]](#footnote-13), makes it much easier for private companies to gain contracts. Judicial Review may be the only way to challenge the lawfulness of any decision.

**The absence of a statutory duty to provide secondary medical services and the creation of ‘sustainable’ healthcare.**

1. There will be no statutory duty on any body to arrange the provision of secondary (i.e. hospital) medical services. The government had a qualified legal duty to provide hospital medical services ‘throughout England’ from 1946 until 2012. Under the H&SC Act 2012, this duty was repealed and clinical commissioning groups (CCGs) were given a duty to arrange provision of medical, and other key services and facilities (under s.3 of the 2006 NHS Act). This duty will now pass to 42 ICBs, **but excluding medical services**. The reasons for this are not given. If enacted, an ICB will be under no obligation to arrange such services. This is particularly concerning in the light of the new payment rules (see above) allowing categories of services not to be paid for. The possibility that has always existed for patients to challenge legally the non-provision of NHS services will be significantly reduced.
2. The systems are expected to meet their local needs and reduce spend by innovating and developing ‘new models of care’[[14]](#footnote-14). The absence of any legal duty to provide medical services creates a new ‘freedom’ for systems to provide alternatives to replace, and also delay or deny the need for elective secondary care. There is no robust evidence that the models, developed and trialled to prevent referral, work in terms of improving outcomes or saving money.[[15]](#footnote-15) Rationing[[16]](#footnote-16) and refusal to offer the ever growing list of Procedures of Limited Clinical Value (PoLCVs)[[17]](#footnote-17) will increase the number of people pressurised to seek care either privately or as ‘NHS paying patients’, creating systems with different spending priorities and ‘two-tiers’ for elective procedures.
3. Also the whole range of ‘cost-efficiency’ measures, which have already begun,[[18]](#footnote-18) can be fully used to try to reduce secondary care costs. An attempt to do this included in the Bill is ‘discharge to assess’[[19]](#footnote-19) developed to clear hospital beds as quickly as possible, but which has caused great concern because of ‘dangerous’ discharges to depleted social services[[20]](#footnote-20) that may increase if new ‘eligibility to reside’ criteria are enforced[[21]](#footnote-21).

**Integrated Care Boards (ICBs) and Integrated Care Partnership committees (ICP) and the private sector.**

1. An ICB must draw up its own constitution and specify its name (Clause 13 and Schedule 2). Under the NHS Act, the name of CCGs had to begin with ‘NHS’: for ICB’s, there are no requirements for this - yet another indication that the Bill, and the ICSs it legitimises, are serving to dissolve the NHS. Further, an ICB constitution does not have to specify its members, and can include representatives from private companies.
2. In Schedule 2 Part 2 the ICB is pronounced as a ‘body corporate’ and as such ‘all members will have shared corporate accountability for delivery of the functions and duties’. If representatives of private companies are members of ICBs, this accountability will conflict with their other legal duties as company directors, in particular the duty to ‘act in the way he (sic) considers, in good faith, would be most likely to promote the success of the company for the benefit of its members as a whole.’
3. The constitution must specify arrangements for exercising the ICB’s functions (Schedule 2 (10)), and this may include through the creation of committees and sub-committees which will carry out its functions, including accountability for NHS spend and performance within the system (EN38). These committees may consist entirely of, or include, persons who are not members or employees of the ICB – with the potential to include representatives from private companies.
4. Under Clause 20 (4) an ICP joint committee must be set up by each ICB and each responsible LA whose area coincides with, or falls partly within, the ICB area (new section 116ZA). The ICP committee will have one member appointed by the ICB, one by each LA, and others appointed by the ICP. It will bring together health, social care, public health and necessary others such as social care providers or housing providers (EN 40). Social care providers are overwhelmingly private, and the open-ended description is explicit in the Bill where, when appointing its members, ‘an ICP may determine its own procedure (including quorum)’.
5. Throughout the Bill there are no details at all on how the public will influence decisions of the ICB. The only reference to ICB transparency is at Schedule 2 (11) (2): ‘The constitution must also specify the arrangements to be made by the ICB for securing that there is transparency about the decisions of the board and the manner in which they are made.’ The Freedom of Information Act will apply (Schedule 4 (60)) but that will have its exclusions for commercial activities and legal advice.

**Diminished powers of Local Authorities (LAs) in meeting local needs and NHS reconfigurations**

1. LAs and ICBs (in their role as replacing CCGs) must undertake a joint strategic needs assessment (JSNA) of the health and social care needs for each authority's area to ‘determine what will be needed in terms of the discharge of health and social care functions’ [[22]](#footnote-22). Under Clause 20 116ZB an ICP must use the JSNA to prepare its ‘integrated care strategy’ and then send this to the ICB(s) and the LAs who may supplement it if necessary as a ‘a joint local health and wellbeing strategy’. After all this local effort however, NHSE, LAs and importantly the ICB will only need to ‘have regard to’ the strategies when making decisions ‘so far as relevant’[[23]](#footnote-23).
2. In Schedule 6 of the Bill, the retained LA powers to refer NHS reconfigurations to the Secretary of State (SoS) could be diminished because of new powers the SoS has to initiate plans for reconfigurations, ‘call in’ plans at any time, and retake any decision made by an NHS body. Commissioning bodies will have a duty to report current and possible future decisions that require or may require reconfiguration[[24]](#footnote-24). This suggests the possibility of intervention in support of a reconfiguration before local scrutiny can act, pre-empting challenges to plans, and public scrutiny.

**Professional deregulation and workforce restructuring**

1. In the NHSE’s Integrated Care Systems: Design Framework[[25]](#footnote-25) it is stated that providers are to ensure services are arranged in a way that is ‘sustainable and in the best interests of the population’, and in the People Plan[[26]](#footnote-26) to achieve this ICSs are felt to require a ‘flexible’, ‘agile’ workforce able to move rapidly between disciplines and providers, with staff potentially ‘passported’ between organisations across and beyond a system. Such changes will depend upon the use of similar digital technologies in clinical activities across services, and while they may be cost-efficient, they are likely to impact on teamwork and continuity of care, affecting the quality of patient care as well as staff morale. They may also place unreasonable demands on staff, given the geographical size of ICSs and extra travel involved.
2. There is a further ambition that technology, including algorithmic decision-making tools, will allow the professional deregulation of various groups of staff,[[27]](#footnote-27) while Clause 123 gives the SoS the power to use secondary legislation to remove a healthcare profession from regulation and abolish its regulatory body. Our concern is that this will weaken standards of training and competence, allow the down-banding of staff and put patients at risk[[28]](#footnote-28). Firstly, a growing dependence on algorithms ignores that these are not value free but subject in their development to human error and bias, as was so dramatically shown in the ‘biased school exam results’ in 2020[[29]](#footnote-29). Secondly, without sufficient learned clinical judgement, the health workers using these systems may be unaware of computer decision errors or when they should seek advice. Computer systems can crash, from power failures, viruses and software bugs, and under-qualified workers may be unable to cope when this happens.

**Data, the use of analytics, and other concerns**

1. Clinical activity, costs and ‘outcomes’ will be monitored in real time and data stored for planning and analytics. As accountable care requires ‘best value for the system’ to be the primary measure to decide where to spend a limited budget[[30]](#footnote-30), all health conditions need to be developed as ‘currencies’[[31]](#footnote-31) so that they can be compared ‘as in a market’ using health and social care data and analytics. In this way lesser ‘value’ can be used to explain individual decisions not to provide care.
2. Clause 81 of the Bill concerns an amendment on ‘dissemination of information’ which appears to want to put beyond doubt NHS Digital’s power to share huge amounts of health or adult social care data, including that for commissioning, planning, policy and development, population health management, and developing innovative approaches and technologies for service delivery. Widely expressed concerns about growing commercial access to data[[32]](#footnote-32) can only unfortunately be strengthened by reading clause 81 while glancing at NHS England’s ‘Health Systems Support Framework’. This includes some 200 organisations - almost all of them private, many based abroad and at least 30 from the US - all accredited to support the widespread development and use of IT in Integrated Care Systems and so with unprecedented access to patient data. Our concerns include that NHS data, once uploaded, may well find its way abroad where it may not have the same privacy protections that the UK currently requires.

**Conclusion**

1. KONP finds the problems identified with the Bill are substantial, with serious implications for the future of the NHS as a comprehensive, universal healthcare system that is publicly funded and publicly accountable. There are also serious concerns for patient safety with the proposed future deregulation of the professions and the ‘flexible’ working it endorses that will only serve to undermine further the morale of staff.
2. At the same time, the Bill does nothing to address: the serious inadequacy of local, primary medical services, community, mental health and hospital services (e.g. staffing and beds) after years of underfunding, service closures and cuts; the corporate take-overs of GP services; the broken social care system; the failings of the centralised communicable disease control system, and the wider public health system.

**Recommendations**

1. There should be: an immediate halt to the progress of the Health and Care Bill and the rollout of ICSs; an extended and meaningful consultation with the public and Parliament to decide how health and social care services are provided in England; the introduction of legislation to bring about a universal, comprehensive and publicly provided NHS, fit for the 21st century as set out in the NHS Bill[[33]](#footnote-33).
1. <https://www.england.nhs.uk/wp-content/uploads/2019/08/13-Whole-Population-Budget-Overview.pdf> [↑](#footnote-ref-1)
2. <https://www.bmj.com/content/365/bmj.l2326> [↑](#footnote-ref-2)
3. <https://inews.co.uk/news/health/nhs-routine-surgery-hip-knee-replacements-savings-76769> [↑](#footnote-ref-3)
4. Fisher, Elliott S.; Staiger, Douglas O.; Bynum, Julie P. W.; Gottlieb, Daniel J. (2007-01-01). Creating Accountable Care Organizations: The Extended Hospital Medical Staff. A new approach to organizing care and ensuring accountability <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2131738/> [↑](#footnote-ref-4)
5. Clause 23 – inserting new sections 223C, 223GB, 233N and 223LA into the 2006 Act: Power to impose financial requirements on ICBs [↑](#footnote-ref-5)
6. Schedule 10 of the Bill. At 114A (3) (e), 114A (6), the Rules for the Payment Scheme which are set by NHS England [↑](#footnote-ref-6)
7. At 114C Private firms can qualify under (8) (a) as licence holders include ‘independent providers’ or under (b) (i) which is a catch-all for services provided ‘for the purposes of the NHS’ or under (b) (ii). [↑](#footnote-ref-7)
8. for example a health service has some social care services commissioned as part of a mixed procurement in the interests of providing joined up care [↑](#footnote-ref-8)
9. Labour laws lost are the International Labour Organisation conventions including Freedom of Assembly and the Right to Strike. [↑](#footnote-ref-9)
10. <http://data.parliament.uk/WrittenEvidence/CommitteeEvidence.svc/EvidenceDocument/Health%20and%20Social%20Care/NHS%20Longterm%20Plan%20legislative%20proposals/written/97675.html> [↑](#footnote-ref-10)
11. NHS. Reg.12(2) PCR2015 [↑](#footnote-ref-11)
12. <https://www.england.nhs.uk/wp-content/uploads/2021/02/B0135-provider-selection-regime-consultation.pdf> [↑](#footnote-ref-12)
13. Quality (safety, effectiveness and experience) and innovation, Value, Integration and collaboration, Access, inequalities and choice, and Service sustainability and social value. [↑](#footnote-ref-13)
14. <https://www.england.nhs.uk/new-care-models/> [↑](#footnote-ref-14)
15. <https://www.nao.org.uk/wp-content/uploads/2017/02/Health-and-social-care-integration.pdf> [↑](#footnote-ref-15)
16. <https://www.bmj.com/content/365/bmj.l4375> [↑](#footnote-ref-16)
17. These used to be called Procedures of Limited Clinical Effectiveness (PoLCEs) but the immaterial nature of ‘value’ broadens the scope of what can be rationed and allows comparison with activities across the system when decisions are to be made about where not to spend the limited budget. [↑](#footnote-ref-17)
18. <https://www.healthemergency.org.uk/pdf/McKinsey%20report%20on%20efficiency%20in%20NHS.pdf> [↑](#footnote-ref-18)
19. EN (156-157) [↑](#footnote-ref-19)
20. <https://www.ombudsman.org.uk/sites/default/files/page/A%20report%20of%20investigations%20into%20unsafe%20discharge%20from%20hospital.pdf> [↑](#footnote-ref-20)
21. <https://www.bmj.com/content/370/bmj.m3747> [↑](#footnote-ref-21)
22. ss.116, 116A and 116B of the Local Government and Public Involvement in Health Act 2007 [↑](#footnote-ref-22)
23. Clause 20 116B [↑](#footnote-ref-23)
24. Clause 38 & Schedule 6; NHS Act 2006, new s.68A & Schedule 10A [↑](#footnote-ref-24)
25. <https://www.england.nhs.uk/wp-content/uploads/2021/06/B0642-ics-design-framework-june-2021.pdf> [↑](#footnote-ref-25)
26. <https://www.england.nhs.uk/wp-content/uploads/2020/07/We-Are-The-NHS-Action-For-All-Of-Us-FINAL-March-21.pdf> [↑](#footnote-ref-26)
27. White paper 5.150 “over time and with changing technology the risk profile of a given profession may change and while regulation may be necessary now to protect the public, this may not be the case in the future.” [↑](#footnote-ref-27)
28. EN-168 calls this ‘the development of a flexible workforce that is better able to meet the challenges of delivering healthcare in the future’. [↑](#footnote-ref-28)
29. <https://www.aiimi.com/insights/2020-grading-algorithm-understanding-what-went-wrong> [↑](#footnote-ref-29)
30. <https://www.kingsfund.org.uk/sites/default/files/2018-10/approaches-to-better-value-october2018_0.pdf> [↑](#footnote-ref-30)
31. <https://www.england.nhs.uk/wp-content/uploads/2019/05/a-new-approach-to-community-healthcare-funding-testing-and-guidance.pdf> [↑](#footnote-ref-31)
32. <https://www.digitalhealth.net/2014/02/care-data-a-media-disaster/> [↑](#footnote-ref-32)
33. <http://www.nhsbillnow.org> [↑](#footnote-ref-33)