SOAS ICOP Policy Briefings

To Inform Government and Parliamentary Debate

Battles commence on Health and Care Bill (1st October 2021)

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New legislation to reform the NHS for the second time in a decade is being pushed through Parliament. Opposition parties, unions, campaigners and think tanks and some Conservatives continue to express concerns at the Health and Care Bill and its consequences, noting that it will divert NHS management time and energy, and **says nothing about the crisis in staffing or the dire state of social care**.

The Bill would give 138 new powers to the Secretary of State, including controversial powers to intervene in local reconfiguration plans, and in the regulation of health professionals – which many fear could result **in deregulation and a dilution of the skill mix in the NHS workforce**.

Trade unions welcome the Bill's proposals to repeal the controversial Section 75 of the 2012 Health and Social Care Act (which requires clinical services above an annual cost of £600,000 to be put out to competitive tender) – though the law has been widely ignored, with only 2 percent of clinical contracts tendered this way. The unions want to go much further, to end tendering for non-clinical services, and to make the NHS the default provider when contracts expire. They also want to **ban trusts and ICSs from establishing "subco" companies** (whether to dodge tax, escape national pay agreements or avoid scrutiny), and **tight regulations on procurement** to prevent the award of crony contracts without competition or scrutiny, like too many contracts during the peak of the Covid pandemic.

NHS England argues that the Bill is about giving legal status to 42 Integrated Care Systems (ICSs) which will replace the Clinical Commissioning Groups established by the 2012 Act. The ICSs are described as "new partnerships between the organisations that meet health and care needs across an area." However, ICSs are far from local: they range in size from 500,000 to 3.2 million population. 26 cover a million or more, and the largest covers a huge coast to coast area in the North of England. **Such large and remote bodies** threaten a drastic reduction in local accountability and **reduced ability to defend threatened services,** with some ICSs **already facing massive financial problems** from the outset.

NHS England guidance emphasises the 'principle of subsidiarity', with 'place-based' decisions taken "as close to local communities as possible": but there is no mention of 'place' or 'subsidiarity' in the Bill, which allows each Integrated Care Board (ICB) to decide its own constitution. **ICB chairs** – appointed from above by NHS England – are not locally accountable at all. With ICB budgets larger than those controlled by most elected Mayors, the argument for **ICB chairs to be elected** is also a strong one. **All ICB business should be in public,** and subject to the **Freedom of Information Act**.

The Bill doesn't require ICBs to include representation of mental health, public health, patients or public. 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**, although the Bill does specifically permit private sector involvement in the advisory Integrated Care Partnerships.

Time is tight to get the Bill through and establish ICBs on a statutory footing from April: but there is still time for MPs and Lords to support many vital amendments. These should, above all, seek to:

- **Prioritise 'place-based' decision making and accountability to local communities, and avoid extending new central powers over local services to the Secretary of State.**
- **Fully reintegrate the NHS by establishing NHS trusts and Foundation Trusts (FTs) as default providers when contracts expire.**
- **Exclude private sector interests from all NHS decision-making bodies.**

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