Health and Care Bill 2021-22

Submission to the Public Bill Committee

From

Professor Allyson Pollock and Peter Roderick,

Population Health Sciences Institute, Faculty of Medical Sciences, Newcastle University

2 September 2021

By email to scrutiny@parliament.uk

Introduction

The Bill is a 'hands-off Bill' which goes in the wrong direction.

It fails to address the serious challenges facing the NHS, public health and social care. We cannot see it making any difference to reducing waiting lists and waiting times for services, to reducing staff shortages, or to providing adequate funding to rebuild and restore capacity in public health services. The 'integration and innovation' narrative is tendentious.

It will neither reinstate the Secretary of State's duty to provide key services throughout England, abolished by the 2012 Health and Social Care Act, nor will it restore and rebuild public services which have been exposed as seriously deficient during the pandemic.

Instead the Bill:

- replaces the principles of universal and comprehensive coverage throughout England with the limited concept of 'core responsibility' for specified groups of people and the conferring of 'discretions' on providers,
- enables further reductions in and closures of services, pushing those who can afford to do so into paying for their health care,
- will lead to some 40+ integrated care boards (ICBs) which will cover areas that are too large to ensure local and public accountability which has already been degraded over many years,

- allows more privatisation and leakage of public money to shareholders with insufficient safeguards over how that money is used,
- will lead to greater variation in provision, access to and levels of services,
- allows private companies to make decisions on allocating public expenditure through their membership of ICBs,
- reduces provision and access to medical services and emergency services,
- further undermines the rights to life and health, and
- conflicts with the NHS constitution.

We urge MPs to oppose it.

Our submission is made in response to the invitation of 15 July 2021 on Parliament's website, and in light of the function of the Public Bill Committee, in the hope that some of the Bill's most damaging aspects may be ameliorated. It follows as far as possible the order in which the provisions of the Bill would be considered pursuant to the proposed motion of Edward Argar as contained in this Amendment Paper.

In particular, our submission includes suggested amendments aimed at ensuring that:

- the NHS in England is a public service, not a market *(see Before Clause 1; page 3),*
- an effective framework for providing comprehensive services is in place *(see Clause 15, Clause 16 and Schedule 3, and Clause 18; pages 9-14),*
- companies are excluded from membership of Integrated Care Boards and Integrated Care Partnerships *(see Clause 13 and Schedule 2, and Clause 20; pages 4-5, 16),*
- ICBs and ICPs must operate transparently (see *Clause 13, After Clause 13, Clause 19, Clause 20 and Clause 25 and Schedule 4; pages 4-7, 17, 18),*
- further loss of local accountability is prevented *(see Clause 19 and Clause 38 and Schedule 10A; pages 15, 19),* and
- the risk of further privatisation is reduced (*see Clause 16 and Schedule 3, and Clause 68; pages 11-13, 20).*

A PowerPoint file which contains screenshots of section 3(1) of the NHS Acts since 1946, and Clause 15 of the Bill, is also attached.

Before Clause 1 – duties of the Secretary of State

The Bill would leave intact section 1 of the NHS Act 2006 as substituted by the Health and Social Care Act 2012, which lays the foundation for a market system in the NHS in England.

As former Labour MP, David Lock QC said in 2019: "The big picture is that you have a market system. If you do not want a market system and you want to run a public service, you need a different form of legal structure."

We submit that the NHS in England should be run as a public system, as it is in the rest of the UK and used to be in England.

The foundation for a public system was removed by the Health and Social Care Act 2012. It had already been weakened by section 1 of the 2006 NHS Act, and should be reinstated, as it was in the NHS Act 1977.[1] This would bring the founding provision for the NHS in England, in line with the founding provision in Scotland, in Wales and in Northern Ireland.

If ICBs are to be established by the Bill in England, an additional sub-section can be inserted to make clear that the Secretary of State may delegate to ICBs the duty to provide or secure the effective provision of services in accordance with that Act.

We suggest the following amendment to the Bill:

Amendment – duties of the Secretary of State

At the start of the Bill, insert-

Duties of the Secretary of State

1 Secretary of State's duties as to the health service
For section 1 of the National Health Service Act 2006 (Secretary of State's duty to promote comprehensive health service) substitute—

"1 Secretary of State's duties as to the health service

(1) It shall be the duty of the Secretary of State to promote in England a comprehensive health service designed to secure improvement—
(a) in the physical and mental health of the people of England, and
(b) in the prevention, diagnosis and treatment of illness,
and for that purpose to provide or secure the effective provision of services in accordance with this Act.

(2) The services so provided must be free of charge except in so far as the making and recovery of charges is expressly provided for, by or under any enactment, whenever passed.

(3) The Secretary of State may delegate the duty to provide or secure the effective provision of services in accordance with this Act to integrated care boards established under this Act."

[1] The main differences between section 1 in the 2006 Act and in the 1977 Act are that the duty to provide or secure 'effective' provision in the latter was omitted in the former, and that that duty was de-coupled from the duty to promote a comprehensive service by placing it in a separate sub-section.

Clause 12 – Role of integrated care boards

We submit that the general function of an ICB should be performed as a delegation of the duty of the Secretary of State to provide or secure provision of services under a reinstated section 1 of the NHS Act 2006. Section 1I of the NHS Act 2006 should reflect this.

Clause 13 – Establishment of integrated care boards

New section 14Z25 of the 2006 Act would give NHS England (NHSE) the duty to establish ICBs by making orders. This should be the duty of the Secretary of State. It gives too much undemocratic power to NHSE.

The number of ICBs is not specified in the Bill. There are currently 42 non-statutory Integrated Care Systems across England. They cover typically a population of over 1 million, covering several local authorities, which is much too big to ensure local accountability. According to the Explanatory Notes, each ICB "will have the ability to exercise its functions through place-based committees" (para. 38), yet the Bill does not recognise these more local structures.

An ICB must have a constitution (s.14Z25 and new Schedule 1B, inserted by Schedule 2 of the Bill).

The constitution must specify the name of the ICB and the area for which it is established. There is no requirement for the name to begin with "NHS" in capital letters, and no provision (as there is in the current NHS Act for CCGs) for the ICB name to comply with prescribed requirements. One of those requirements for CCGs is that its name must begin with "NHS" in capital letters.

An ICB will consist of a chair appointed by NHSE and approved by the Secretary of State; a chief executive appointed by the chair with NHSE's approval; one member jointly nominated by (i) NHS trusts and foundation trusts, (ii) providers of primary medical services, and (iii) by the local authorities in the ICB area; and anybody else, including private companies, in accordance with the ICB's constitution and any regulations. Unlike for CCGs, an ICB constitution will not have to specify its members.

NHSE has stated that "All members of the [ICB] will have shared corporate accountability for delivery of the functions and duties of the ICS". If representatives of private companies are members of ICBs, sharing this accountability will conflict with the legal duties of company directors, in particular the duty to:

> "act in the way he considers, in good faith, would be most likely to promote the success of the company for the benefit of its members as a whole."

It also conflicts with the first of the seven Principles of Public Life (the Nolan principles), namely 'selflessness':

> "Holders of public office should act solely in terms of the public interest."

The constitution must specify arrangements for exercising the ICB's functions, and this may include committees and sub-committees. These committees may consist entirely of, or include, persons who are not members or employees of the ICB – such as private companies.

Conflicts of interest will frequently occur, and are more likely to do so than in the case of CCGs presently. This will be the case even if private companies are excluded from membership. But the Bill does not require them to be prevented, and does not require a register of conflicts of interest to be

proactively published. The concept of 'affecting the integrity of the ICB's decision-making processes', proposed in new section 14Z30(4), is much too vague to provide any confidence that conflicts will be avoided.

We submit that the Bill should establish place-based committees as statutory bodies in order to ensure better local accountability.

We also submit that ICBs should to be named as "NHS ICBs", their constitutions should specify their members, private companies should not be permitted to be members of ICBs or to sit on their committees or sub-committees, conflicts of interests should be prevented from arising and a register of conflicts of interest should be proactively published.

We suggest the following 5 amendments:

In Clause 13

Insert after subsection (4) of section 14Z25 of the NHS Act 2006—

> "(4A) Members of an integrated care board, or of its committees and sub-committees, shall not include any individual who is an officer or employee of a company, or who represents a company."

Insert after subsection (1) of section 14Z30 of the NHS Act 2006—

> "(1A) No person mentioned in subsection (1) shall perform, or participate in performing, any function where that person has or potentially has a conflict of interest."

In subsection (2) of section 14Z30 of the NHS Act 2006, delete the words "or make arrangements to ensure that members of the public have access to the registers on request".

In Schedule2

Delete ", and" at the end of paragraph 2(a) of Schedule 1B of the NHS Act 2006, and insert—
> "(aa) the members of the board, and"

Insert after paragraph 2 of Schedule 1B of the NHS Act 2006—
> "2A. The name of the integrated care board must comply with such requirements as may be prescribed."

After Clause 13 – access to ICB meeting and documents

At present, Schedule 4, paragraph 3 of the Bill adds ICBs to the list of bodies to which the Public Bodies (Admission to Meetings) Act 1960 applies. This list currently includes other bodies such as NHSE, NHS Digital, the CQC and NICE. There is an obligation under this Act for meetings to be open to the public, though the body can by resolution say otherwise "whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings". One such 'special reason' may be where there will be or has been lobbying for private interests - i.e., where there is a "need to receive or consider recommendations or advice from sources other than members, committees or sub-committees of the body".

The press are entitled to ask for and be provided with copies of the agenda (but not members of the public), and may, but do not have to be given, copies of reports and other documents.

The Act only applies to committees if they "consist of or include all members of the body", which will presumably mean that ICB committees and sub-committees will not be covered.

CCGs are not subject to the 1960 Act. Their constitutions must (i) "specify the arrangements made by the [CCG] for securing that there is transparency about the decisions of the group and the manner in which they are made" in general, and must (ii) specifically do so as regards decisions of the governing body, and (iii) the arrangements "must include provision for meetings of governing bodies to be open to the public, except where the [CCG] considers that it would not be in the public interest to permit members of the public to attend a meeting or part of a meeting." Only (i) will apply to ICB constitutions.

The most extensive rights the public have in relation to the meetings and documents of public bodies are in relation to local authorities under Part VA of the Local Government Act 1972.

We therefore suggest the following amendment which would make ICBs subject to the same provisions on access to meetings and documents that apply to principal councils; and require online access to meetings. They would also strengthen the ability of the public to make deputations.

After Clause 13, insert—

"13A. Meetings and documents of integrated care boards

"(1) The National Health Service Act 2006 is amended as follows.

(2) After section 14Z30 (inserted by section 13 of this Act) insert—

14Z30A. Access to meetings and documents of integrated care boards, their committees and sub-committees

(1) The provisions of Part VA of the Local Government Act 1972 (Access to Meetings and Documents of Certain Authorities, Committees and Sub-Committees) shall apply to an integrated care board, its committees and sub-committees, as they do to a principal council and its committees and sub-committees.

(2) The meetings of an integrated care board, its committees and sub-committees shall be shall be open to the public online, streamed live online, and recordings shall be accessible online to the public after the meetings.

(3) An integrated care board shall ensure that members of the public are able to request and make deputations to pose questions and to make presentations at meetings of the board, its committees and sub-committees, and to receive oral and written responses.”"

Clause 14 - People for whom integrated care boards have responsibility

The title of this clause is misleading, and its contents unclear and unexplained.

In 2012, the duty on each CCG was to arrange provision of key services "for persons for whom it has responsibility". This term was defined in the primary legislation as persons provided with primary medical services by a CCG member and others who usually reside in the CCG's area and are not provided with such services by a CCG member, with powers for the Secretary of State both to add and to exclude persons.

Under a new s.14Z31, NHSE would make rules for determining "the ***group of people*** for whom each [ICB] has ***core*** responsibility" (emphases added). This evokes the US definition of a health maintenance organisation which provides "basic and supplemental health services to its members."

According to the Bill, those rules must ensure that everyone who is provided with NHS primary medical services, and everyone who is usually resident in England and is not provided with NHS primary medical services, is allocated to at least one group, subject to any exceptions made by regulations. There would be no requirement of residence in the ICB area. The ICB must then arrange provision of key services for the group of people allocated to the ICB by NHSE's rules, and such other people as may be prescribed (clause 15, inserting a new section 3 into the 2006 Act).

Why the concept of "core" responsibility has been introduced is not explained, and its meaning is unclear. It appears that the need for the concept arises because NHSE is to be given the power to allocate people to groups and thus to ICBs. There is no indication of how this must be done, why people can be allocated to more than one group and no mention of a right of appeal. It is no longer possible for people to know, on the face of the legislation, who is responsible to them for arranging the key services in section 3. We submit that Parliament should not give NHSE this power.

Bizarrely, subsection (4) of new section 14Z31 proposes to give the Secretary of State a power to replace section 14Z31 with a new section which would provide that "the group of people for whom an [ICB] has core responsibility are to the people who usually reside in its area", subject to prescribed exceptions. Why is this exceptional power to amend primary legislation needed? Why is residence in the ICB area not the starting basis for ICB responsibility and the basis for service provision for local residents?

Clause 15 - Commissioning hospital and other health services

Clause 15 raises some of the most worrying points of detail in the Bill. Its title is misleading.

The government had a qualified legal duty to provide hospital medical services "throughout England" from 1946 until 2012.[2] Under the Health and Social Care Act 2012, this duty was repealed and 200+ clinical commissioning groups (CCGs) were given a duty to arrange provision of medical, and other key services and facilities, such as nursing and ambulance services, and hospital and other accommodation.

Under the Bill, the duty to arrange provision of these services and facilities will pass to some 42 ICBs under an amended s.3 of the NHS Act 2006, but excluding medical services.

Ophthalmic services, included in section 3 since 1977, would also be excluded.

In addition, the Bill would remove the provision in the current section 3(1C) aimed at ensuring that emergency services are provided for everyone present in the commissioner's area, which is operationalised and supplemented in the NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (where it extends to ambulance and accident as well as to emergency services).

We suggest the following 3 amendments to Clause 15 of the Bill to rectify these omissions:

In Clause 15

insert after paragraph (b) of subsection 3(1) of the NHS Act 2006—

> "(c) medical services other than primary medical services (for primary medical services, see Part 4),"

before "nursing" in paragraph (d) of subsection 3(1), insert "ophthalmic,", and

remove "and" at the end of paragraph (a) of subsection 3(2) of the NHS Act 2006, and insert—

> "(b) every person present in its area in relation to accident and emergency and ambulance services, and"

Moreover, these omissions should be seen in the light of the Bill – in four instances - containing provisions to permit contracts to give the service providers "discretions…in relation to anything to be provided under the" contracts.

These provisions apply to contracts for all services listed in section 3 as modified by Clause 15, as well as for primary medical services (such as Alternative Provider Medical Services), general medical services, personal medical services and services commissioned by NHSE.

They would allow providers under contracts in effect to overrule the statutory regime – already weakened by Clause 15 –as well as to clearly contradict the NHS Constitution which states that:

[2] Screenshots of the provisions of section 3 of the various NHS Acts since 1946 are included in the powerpoint file submitted to the Public Bill Committee with this submission.

> "You have the right to receive care and treatment that is appropriate to you, meets your needs and reflects your preferences".

Section 3 is a fundamental part of the NHS framework, and the combined effect of the omissions in Clause 15, and of the 'discretions' which may be afforded to providers would also undermine the State's duty to provide an effective framework as part of the positive obligation to secure the right to life under the Human Rights Act 1998 and the European Convention on Human Rights to which the Joint Human Rights Committee drew attention in its 2019-21 7th report (The Government's response to COVID-19: human rights implications, paragraph 65).

We therefore suggest below amendments to Schedule 3 (see Clause 16) and Clause 18 to remove these 'discretions'.

Clause 16 and Schedule 3, Part 1 - Commissioning primary care services etc.

Schedule 3, Part 1 contains provisions to permit contracts to give the providers of primary medical services (such as Alternative Provider Medical Services), general medical services, personal medical services and services commissioned by NHSE "discretions…in relation to anything to be provided under" their contracts. (Clause 18 does the same for providers of s.3 services.)

They would allow providers' contracts in effect to overrule the statutory regime – already weakened by Clause 15 –as well as to contradict the NHS Constitution and to undermine the State's duty to provide an effective framework as part of the positive obligation to secure the right to life (see further above under Clause 15).

We suggest the following amendments to Schedule 3, Part 1:

In paragraph 3 of Schedule 3, Part 1, inserting a new section 83(4) into the National Health Service Act 2006—
"Omit new section 83(4)."
In paragraph 4 of Schedule 3, Part 1, inserting a new section 84(4B) into the National Health Service Act 2006—
"Omit new section 84(4B)."
In paragraph 9 of Schedule 3, Part 1, inserting a new section 92(5A) into the National Health Service Act 2006—
"Omit new section 92(5A)."

Abolition of APMS contracts

When the NHS was set up under the NHS Act 1946, arrangements were made with medical practitioners to provide personal medical services to people in the local area. These services were described as 'general medical services' (GMS). Following national negotiations, 'terms of service' were set out in regulations and incorporated into the arrangements. There was no contract in the legal sense of a tradeable asset which could be passed on to others, for example through assignment or sub-contracting; and the word 'contract' did not appear anywhere in the primary or secondary legislation.

One of the final statutes enacted under the Major government was the NHS (Primary Care) Act 1997. It introduced 'pilot schemes' for more locally flexible 'personal medical services (PMS) agreements'. These could be made between a health authority (in England and Wales) and a number of eligible persons, including GPs and NHS trusts, but also companies limited by shares where the shares were held by a trust or GPs.

In 2003 the Health and Social Care (Community Health and Standards) Act introduced contracts. As well as having the duty to provide or secure provision of primary medical services within their area, and a power to provide such services directly, Primary Care Trusts were also given the power to make arrangements for their provision, and in particular to

make contractual arrangements with any person. This included arrangements with companies limited by shares. No restriction on share ownership was stipulated in the legislation. Alternative Provider Medical Services (APMS) contracts were devised in the exercise of this power, following directions from the Secretary of State, not regulations which need to be laid before Parliament.

The power to enter into APMS contracts passed to NHSE in 2012, and the Bill will now pass this power to ICBs.

APMS contracts have been described by a health industry lawyer as "the private sector's gateway to providing primary health care to NHS patients". This is because when Parliament created the two main GP contract types - General Medical Services (GMS) contracts, and Personal Medical Services (PMS) agreements – it ensured that the private sector was not eligible to hold them. It allowed companies limited by shares to hold these two types, but imposed restrictions on the identity of their shareholders. In summary, only companies with GPs, regulated health professionals and (for PMS agreements) NHS trusts and foundation trusts, as shareholders can hold them.

Major companies awarded APMS contracts are reported to have failed: e.g., UnitedHealth for the Camden Road surgery in London in 2008, which no longer exists; Atos pulled out of St Paul's Way medical centre in Bow in 2011; Serco pulled out of its out-of-hours contract in Cornwall in 2013, after a damning Select Committee report; and The Practice Group, a majority-owned Centene company, pulled out of the Osler House surgery in Harlow, Essex in 2018, according to the Daily Mail.

Most recently, in early 2021, at least 34 APMS contracts across London were in effect transferred to Operose Health Limited, a subsidiary of the giant US health company, Centene Corporation. This was achieved by the company which held the contracts, AT Medics Limited, transferring the ownership of its holding entity, AT Medics Holdings LLP, to Centene subsidiaries.

According to NHS Digital, there were 180 APMS practices in England in 2019-20, covering just over 1 million (and 1.8% of) registered patients. These can be seen on this map compiled by Dr Paul O'Brien.

Parliament should take back control of who is eligible, directly and indirectly, to hold contracts for primary medical services by abolishing APMS contracts and ensuring that GMS contracts and PMS agreements cannot be sub-contracted, assigned or novated to any person who is not eligible to enter into the contract or agreement. The amendments we suggest below are intended to achieve that:

In paragraph 3 of Schedule 3, Part 1, inserting a new section 82B into the National Health Service Act 2006, remove the full stop at the end and insert the following—

"by entering into general medical services contracts in accordance with section 84, or personal medical services agreements in accordance with section 92"

In paragraph 3 of Schedule 3, Part 1, inserting a new section 83 into the National Health Service Act 2006—

"Omit new section 83."

After paragraph 5 of Schedule 3, Part 1, insert—

"(5A) Any person to whom a general medical services contract may be sub-contracted, assigned or novated must—

(a) be a person eligible to enter into a general medical services contract, and

(b) if the person is a company, limited liability partnership or any other form of corporate entity it must be entirely owned and controlled by a person eligible to enter into a medical services contract."

After paragraph 9(4) of Schedule 3, Part 1, insert—

"(4A) Any person to whom an agreement under this section may be sub-contracted, assigned or novated must—

(a) be a person eligible to enter into such an agreement, and

(b) if the person is a company, limited liability partnership or any other form of corporate entity it must be entirely owned and controlled by a person eligible to enter into such an agreement."

Clause 18 - Commissioning arrangements: conferral of discretions

This clause would permit contracts to give the providers "discretions…in relation to anything to be provided under" their contracts.

Taken with the discretions also to be given in relation to primary medical services (Clause 16 and Schedule 3, Part 1), and the weakening of section 3 by Clause 15, providers would be able in effect to overrule the statutory regime as well as to contradict the NHS Constitution and undermine the State's duty to provide an effective framework to secure the right to life (see above).

We therefore suggest this amendment:

In clause 18 "Omit Clause 18"

Clause 19 –General functions

New section 14Z42 - Duty to promote integration

We welcome the express recognition that provision of housing accommodation is a health-related service, in new section 14Z42(4).

New section 14Z44 - Public involvement and consultation by integrated care boards

ICBs will have a duty to make arrangements to secure that individuals to whom the services are being or may be provided, and their carers and representatives, are involved in the planning of commissioning arrangements, and in the development and consideration of proposals for changes that would impact on the manner in which the services are delivered and/or the range of services. This is the same duty that is currently imposed on CCGs (s.14Z2(2) of the NHS Act 2006).

Under section 14Z2(3) of the NHS Act 2006, CCGs must also describe in their constitutions the arrangements made by them in this regard, and include a statement of principles which they will follow in implementing those arrangements. New section 14Z44 would omit these duties currently on CCGs. ICBs should have the same duties as CCGs in this regard and so we suggest the following amendment:

Clause 19

Insert after subsection (2) of new section 14Z44 of the NHS Act 2006—

"(2A) The integrated care board must include in its constitution—

(a) a description of the arrangements made by it under subsection (2), and

(b) a statement of the principles which it will follow in implementing those arrangements."

New section 14Z49 - Guidance by NHS England

The new section 14Z49 omits the duty currently on NHSE (under section 14Z8(3) of the 2006 Act) before publishing, and significantly revising, commissioning guidance for CCGs to consult with Healthwatch England. This duty should also apply to guidance for ICBs.

Clause 19

Insert after subsection (2) of new section 14Z49 of the NHS Act 2006—

"(3) NHS England must consult the Healthwatch England committee of the Care Quality Commission—

(a) before it first publishes guidance under this section, and

(b) before it publishes any revised guidance containing changes that are, in the opinion of the Board, significant."

After Clause 19 – review and scrutiny

A local authority has power to "review and scrutinise any matter relating to the planning, provision and operation of the health service" under Part 4 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. Those provisions were made by the Secretary of State under section 244 of the NHS Act 2006.

ICBs will almost always cover several local authority areas. But many decisions will be taken at so-called 'place' level, which will be smaller than an ICB area. Yet 'places' are not mentioned or acknowledged in the Bill.

If local authority review and scrutiny is not linked to the level at which decisions are made, both at ICB and place-level, then there will be a further significant dilution of local accountability.

The following amendment is therefore aimed at ensuring review and scrutiny powers operate at the lowest level at which decisions will be made, as well as at ICB level.

After Clause 19, insert—

"**19A Review and scrutiny**

The Secretary of State shall exercise his powers under section 244 of the NHS Act 2006 (review and scrutiny by local authorities) to ensure that review and scrutiny by a local authority of any matter in connection with the planning, provision and operation of the health service in its area which relates to the functions of an integrated care board occurs at the most local level."

Clause 20 - Integrated care partnerships and strategies

ICP membership

The possibility of representatives of companies being members of ICPs should not be allowed, as this conflicts with the legal duties of company directors and the Nolan principles (see Clause 13 above).

We therefore suggest this amendment:

In Clause 20(4), after subsection (2) of new section 116ZA of the Local Government and Public Involvement in Health Act 2007, insert—

"(2A) Members of an integrated care partnership, or of its sub-committees, shall not include any individual who is an officer or employee of a company, or who represents a company."

Access to ICP meeting and documents

ICPs (unlike ICBs) will not be added to the list of bodies to which the Public Bodies (Admission to Meetings) Act 1960 applies.

The most extensive rights the public have in relation to the meetings and documents of public bodies are in relation to local authorities under Part VA of the Local Government Act 1972.

We therefore suggest the following amendments which would make ICPs subject to the same provisions on access to meetings and documents that apply to principal councils, and to require online access to meetings. They would also strengthen the ability of the public to make deputations. (These amendments mirror those that would apply to ICBs pursuant to the amendments we have suggested 'After Clause 13' above.)

In Clause 20(4), after subsection (3) of new section 116ZA of the Local Government and Public Involvement in Health Act 2007, insert—

"(4) The provisions of Part VA of the Local Government Act 1972 (Access to Meetings and Documents of Certain Authorities, Committees and Sub-Committees) shall apply to an integrated care partnership, and any sub-committee, as they do to a principal council and its committees and sub-committees.

(5) The meetings of an integrated care partnership and any sub-committee shall be open to the public online, streamed live online, and recordings shall be accessible online to the public after the meetings.

(6) An integrated care partnership shall ensure that members of the public are able to request and make deputations to pose questions and to make presentations at meetings of the partnership and of any sub-committee, and to receive oral and written responses."

Clause 25 and Schedule 4 -Integrated care system: further amendments

The Bill currently makes ICBs subject to the Freedom of Information Act 2000 (Schedule 4, paragraph 60, which would add ICBs to Part 3 of Schedule 1 to the Freedom of Information Act 2000 (NHS in England and Wales). There is no similar provision for ICPs. The following amendment would therefore bring ICPs within the 2000 Act as well.

At the end of paragraph 60 of Schedule 4 (see Clause 25), insert—

"after paragraph 37B insert—

"37C An integrated care partnership established under section 116ZA of the Local Government and Public Involvement in Health Act 2007."

Clause 38 - Reconfiguration of services: intervention powers - and Schedule 6

This clause and Schedule 6 of the Bill would give new powers to the Secretary of State in relation to a change in the arrangements for the provision of NHS services where that change impacts on the manner in which a service is delivered to individuals (at the point when the service is received by users), or the range of health services available to individuals – a "reconfiguration of NHS services".

Currently, the Secretary of State can only intervene following a local authority referral made under Part 4 of The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 where "any proposal for a substantial development of the health service in the area of a local authority…, or for a substantial variation in the provision of such service" is under consideration and several pre-conditions are met.

According to the Explanatory Notes, these new powers would require "a reconfiguration to be referred to him instead of being dealt with locally" and "[t]o support this intervention power, the current Local Authority referral power…will be amended to reflect the new process. This does not remove the local Health Oversight and Scrutiny Committee (HOSC) role or the requirement to involve them in reconfigurations" (paragraph 95).

If these new powers are enacted, the continued role of HOSCs and what amendments will be made to the 2013 Regulations, are unclear, as is the reason why the triggers for the Secretary of State's intervention and for a local authority's referral would be different.

Moreover, the new powers include a power for the Secretary of State to direct ICBs and/or NHSE to consider a reconfiguration (paragraph 6 of new Schedule 10A of the NHS Act 2006). No limitation on this power is expressed. It could easily be used with a view to reducing services.

Most fundamentally, if these provisions are enacted, they would amount to a further centralisation of power and another incremental loss of local accountability. Community Health Councils (CHCs) used to have the duty to represent the interests of the local public in the health service and were able to refer reconfigurations to the Secretary of State. This ability disappeared when CHCs were abolished by the NHS Reform and Health Care Professions Act 2002. Following their abolition, local authorities were given the referral power, and now the Secretary of State wants to have a direct power to intervene instead of local authorities. The direction of travel should be back towards greater local accountability not towards greater centralisation of power.

We therefore suggest the following amendment:

Clause 38 and Schedule 6 "Omit clause 38 and Schedule 6.""

Clause 68 - Procurement regulations

The Bill lays the foundation for out sourcing the provision of health services. It also fails to implement the strong recommendation of the House of Commons Select Committee in June 2019 that:

> "79.We strongly recommend that legislation should rule out the option of non-statutory providers holding an ICP contract. Doing so would allay fears that ICP contracts provide a vehicle for extending the scope of privatisation in the English NHS."

We therefore suggest the following amendments aimed at establishing the NHS as the default provider, and at implementing the Committee's recommendation.

In order to minimise out sourcing, the amendments below would also require ICBs to consult with the public if they propose to award contracts other than to NHS trusts and NHS foundation trusts, and to publish fully, without any claim to commercial confidentiality, all proposals for contracts, the contracts themselves and the outcomes of regular contract monitoring. The amendments would also prohibit contracts being awarded to private providers who do not give their staff at least the equivalent of NHS terms and conditions.

In Clause 68, after subsection (3) of new section 12ZA of the National Health Service Act 2006, insert—

"(3A) The regulations shall make provision to ensure that—

(a) there is a presumption in favour of contracts being awarded to NHS trusts and NHS foundation trusts,

(b) integrated care provider contracts are not be awarded to a person other than to an NHS trust or an NHS foundation trust,

(c) if an NHS trust or an NHS foundation trust does not consider that it is able, or does not wish, to provide certain services, it must publish their reasons,

(d) if paragraph (c) applies, but subject to paragraph (b), the integrated care board must consult with the public if it proposes to award any contract for those services to any person other than an NHS trust or NHS foundation trust, and

(e) the board must in any such consultation—

(i) set out its response to the reasons mentioned in paragraph (c),

(ii) specify the parties to and the full terms and conditions of the proposed contract, and

(iii) confirm that the terms and conditions for staff under the proposed contract would be at least equivalent to NHS terms and conditions."