

**Health Bill call for evidence:
Submission from the National AIDS Trust**

1. Introduction

- 1.1. National AIDS Trust is the UK's HIV rights charity. We work to stop HIV from standing in the way of health, dignity and equality, and to end new HIV transmissions.
- 1.2. We welcome the Government's 10 Year Health Plan and the commitment it reinforces, to end new HIV transmissions in England by 2030 through delivering the updated HIV Action Plan for England 2025-2030.
- 1.3. The legislative framework for wider health policy set out in the Health Bill provides further routes towards achieving improved quality of life for people living with HIV through the health service. The three shifts outlined in the 10 Year Health Plan - hospital to community, analogue to digital, and sickness to prevention - can contribute towards meeting the goals of ending new HIV transmissions, supporting people to live well with HIV, and tackling growing health inequalities.
- 1.4. The next phase of health service reform laid out in the Health Bill creates opportunities to drive the delivery of the Government's 2030 targets for the HIV response. However, without strong safeguards and the right action from Integrated Care Boards (ICBs), these reforms could risk furthering barriers to care and regional variations on service availability, particularly for communities already underserved.
- 1.5. This submission sets out evidence and recommendations related to ICB commissioning of specialised services, community and voluntary sector involvement, mental health, digital reform and health inequalities, and proposes two new amendments to strengthen co-production in neighbourhood health plans and a new power to enable reservation and prioritisation of contracts for the voluntary sector.

2. Strengthening NHS partnership with the voluntary sector

- 2.1. The Health Bill's provisions on neighbourhood health services place ICBs and local authorities at the centre of planning and delivering community-based care. This shift is welcome, but the Health Bill lacks a clear duty to ensure co-production with and the meaningful involvement of the voluntary, community and social enterprise (VCSE) sector, despite the sector's key role in delivering health services and improving outcomes. As explored in the National AIDS Trust and One Voice Network's Unheard Voices report¹, meaningful involvement recognises lived experience as a form of expertise. In practice, this means engaging affected communities and organisations in identifying needs, shaping service design, informing decision-making and ensuring lived experience informs delivery and evaluation. Co-production goes further, involving people and communities as equal partners in the design, development and improvement of services that they use, or may use in future.

¹ National AIDS Trust, One Voice Network (2024) Unheard Voices. Available at: <https://nat.org.uk/wp-content/uploads/2024/06/UnheardVoices.pdf>

- 2.2. HIV VCSE organisations already deliver many of the functions the Bill seeks to expand, including:
 - 2.2.1. community-based and preventative services
 - 2.2.2. mental health and psychosocial support
 - 2.2.3. support addressing wider determinants such as housing, employment and stigma
- 2.3. These services are critical to engagement in care, prevention, and quality of life. However research from HIV Outcomes UK² highlights that provision in England is highly variable, with a postcode lottery in access to peer support, counselling, and other essential services, particularly outside cities.
- 2.4. While the Bill strengthens local planning structures, it does not require ICBs or local authorities to:
 - 2.4.1. involve VCSEs in neighbourhood health plans
 - 2.4.2. integrate VCSE provision into care pathways
 - 2.4.3. include VCSE representation in governance arrangements
- 2.5. Despite welcome recognition of the important role of VCSEs within the 10 Year Health Plan and guidance for how ICBs on how they should partner with VCSEs, the sector is not consistently involved in commissioning or strategy development, and local strategies often fail to reflect the needs of marginalised communities and people with long-term health conditions. For example, research from the National AIDS Trust and the One Voice Network found that half of London local authorities reported not involving community members in HIV procurement and tender processes, indicating limited engagement in local authority commissioning, including with VCSEs organisations.³
- 2.6. While it is welcome that Clause 24 on neighbourhood health plans requires the ‘responsible local authority and each of its partner integrated care board’ to involve people who live or work in the area, without stronger requirements for co-creation and meaningful engagement with NHS patients and VCSE organisations, there is a risk that plans will fall short of genuine participation and instead could entrench existing regional inequalities in access to services and health outcomes. Evidence shows that meaningful involvement is critical to developing more effective, trusted and equitable services.⁴ This is particularly important for marginalised and underserved communities, who may not benefit from improvements seen in the wider population if services are not designed with their needs and experiences in mind. Therefore, neighbourhood health plans should be co-produced with communities and VCSE organisations to ensure that service design, delivery and evaluation reflect lived experience and community need.

Proposed amendment: Voluntary sector’s role in neighbourhood health plans
Clause 24, page 18, line 8, at end insert-

² National AIDS Trust (2025) HIV Services at the crossroads. Available at: <https://nat.org.uk/publications/hiv-services-voluntary-sector-crossroads-crisis-report/>

³ National AIDS Trust, One Voice Network (2024) Unheard Voices. Available at: <https://nat.org.uk/wp-content/uploads/2024/06/UnheardVoices.pdf>

⁴ *ibid*

In preparing a neighbourhood health plan, a responsible local authority and integrated care board must take and demonstrate reasonable steps to ensure the plan is co-produced with meaningful involvement of the voluntary, community and social enterprise sector in that area, including the development, design, implementation, monitoring and evaluation of the plan.

In complying with this, they must in particular have regard to-

- (a) organisations representing people with lived experience of health conditions;
- (b) organisations working with underserved or marginalised populations; and
- (c) the role of voluntary, community and social enterprise organisations in delivering community-based services.

(5C) The responsible local authority and integrated care boards must demonstrate how they have ensured ongoing and meaningful representation of voluntary, community and social enterprise organisations across the governance, decision-making and commissioning arrangements relating to neighbourhood health plans at all stages of the planning process.

3. Reservation and prioritisation of VCSE contracts in NHS commissioning

- 3.1. The Health Bill expands the role of ICBs as strategic commissioners and reinforces the shift towards community-based care. However, it does not sufficiently address the often limited and inconsistent involvement of VCSEs in the commissioning and delivery of NHS services.
- 3.2. NHS commissioners have some flexibility under the Provider Selection Regime⁵ to directly award contracts to a VCSE organisation using the most suitable provider process or through a competitive process to select a VCSE provider where it scores best against the criteria. However commissioners are not able to formally reserve healthcare contracts and competitive processes specifically for the VCSE sector. As a result, this contributes to how the availability of VCSE provided services is variable and inconsistent across systems, despite their recognised role as key delivery partners.
- 3.3. There is less flexibility within NHS commissioning to prioritise the role of VCSEs compared to local authority commissioning. Through the Public Services (Social Value) Act 2012⁶ and the Local Government (Exclusion of Non-commercial Considerations) (England) Order 2026⁷, local authorities have greater flexibility within procurement frameworks to:
 - 3.3.1. reserve certain contracts for the VCSE sector (particularly below threshold)
 - 3.3.2. design commissioning approaches that prioritise social value and community-based provision

⁵ NHS England. NHS Provider Selection Regime. Available at: <https://www.england.nhs.uk/commissioning/how-commissioning-is-changing/nhs-provider-selection-regime/>

⁶ Public Services (Social Value) Act 2012. Available at: <https://www.legislation.gov.uk/ukpga/2012/3>

⁷ The Local Government (Exclusion of Non-commercial Considerations) (England) Order 2026. Available at: <https://www.legislation.gov.uk/ukdsi/2026/9780348277104>

- 3.4. This creates an uneven landscape across systems, with VCSE organisations more readily embedded in local authority services than in NHS-commissioned provision.
- 3.5. Research from HIV Outcomes UK⁸ demonstrates that VCSE organisations are often best placed to deliver the kinds of services the Bill seeks to expand through neighbourhood health and the shift from hospital to community. But despite their value, VCSE organisations face barriers in accessing NHS commissioning. From a recent FOI request, several ICBs highlighted that don't commission HIV VCSEs to deliver HIV support services. This is despite services like peer support being part of the national service specification on adult specialised services for people living with HIV. In addition, HIV VCSEs have reported that complex, bureaucratic NHS procurement processes make it difficult for smaller community organisations to compete and that commissioning structures often favour larger providers, sidelining HIV VCSEs.⁹
- 3.6. The UK Government's Civil Society Covenant notes that the Government 'supports collaborative commissioning and procurement models, recognising the inherent social value civil society brings' and highlights goals to make the NHS the world's most collaborative public healthcare providers and to harness partnerships with the voluntary sector. In addition, the UK Government's National Procurement Policy Statement¹⁰ aims to give VCSEs in England a fair chance at public contracts, creating high quality jobs and championing innovation. To deliver on these Government commitments, NHS commissioners should work to address the barriers for VCSEs to be involved in delivering contracted services. This includes allowing sufficient time for organisations to respond to procurement processes, offering contracts of adequate length, and ensuring full-cost recovery is built into commissioning arrangements. NHS commissioners should also have the power to enable reservation and prioritisation of contracts for the VCSE sector to help ensure delivery of essential services and to recognise the crucial role that the VCSE sector plays in delivering the 10 Year Health Plan, including the commitments to the UK's HIV response.
- 3.7. Bringing NHS commissioning approaches into closer alignment with the more flexible and enabling approaches available to local authorities will help deliver on shifting care from hospital to community, and help deliver integrated, whole-person care. As proposed below, the Bill should be strengthened to include a duty on ICBs to prioritise VCSE providers best placed to deliver community-based and preventative services, particularly for underserved populations.

Amendment - Reservation and prioritisation of VCSE contracts in NHS
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⁸ National AIDS Trust (2025) HIV Services at the crossroads. Available at: <https://nat.org.uk/publications/hiv-services-voluntary-sector-crossroads-crisis-report/>

⁹ *ibid*

¹⁰ Cabinet Office (2025) National Procurement Policy Statement. Available at: https://assets.publishing.service.gov.uk/media/67ab330e1a116437c7ed88da/E03274856_National_Procurement_Policy_Statement_Elay.pdf

commissioning

Clause 16, page 13, line 36, at end insert -

Power to enable reservation and prioritisation of contracts for the VCSE sector

- (1) In exercising their commissioning functions, Integrated Care Boards must take reasonable steps to secure the participation of voluntary, community and social enterprise organisations in the provision of services.
- (2) Regulations must enable Integrated Care Boards to be able to reserve and/or prioritise contracts to be delivered by voluntary, community and social enterprise organisations as part of their commissioning process.
- (3) Circumstances in which contracts may be appropriate to be reserved or prioritised under subsection (2) include-
 - (a) services that are, or could be, community-based;
 - (b) services that are intended to reach populations that are underserved, marginalised, or experiencing health inequalities; or
 - (c) Where voluntary, community and social enterprise organisations are best-placed to deliver person-centred and/or culturally competent care.
- (4) In exercising functions under this section, Integrated Care Boards must have regard to-
 - (a) the need to reduce health inequalities
 - (b) the importance of securing equitable access to services across different areas; and
 - (c) the sustainability of voluntary, community and social enterprise provision, including through appropriate contract length and funding arrangements.

4. Delegation of specialised services to ICBs and meeting national standards

- 4.1. As part of the delegation of specialised services, ICBs are now responsible for planning and commissioning adult specialist services for people living with HIV. It is the responsibility of the ICBs to ensure the services meet the national service specification on adult specialised services for people living with HIV¹¹ and this should be delivered in accordance with British HIV Association (BHIVA) standards and guidance.
- 4.2. However in the context of wider changes in the NHS and a challenging funding landscape, there is a risk that HIV will be insufficiently prioritised, regional variation of service provision will be entrenched, and the vital role of the HIV voluntary and community sector will be undervalued.
- 4.3. For people living with HIV, variation in service provision can have serious consequences. For example, some people living with HIV in England may face restricted access to specialist multidisciplinary care, limited opportunities to be re-engaged in care, and challenges in the effective management of co-morbidities. This can lead to poorer health outcomes, increased risk of preventable comorbidities, preventable onward HIV transmissions, and widen health inequalities among people living with HIV.
- 4.4. There is an urgent need to ensure that ICBs appropriately prioritise HIV and deliver the commitments set out in the HIV Action Plan through effective local action. Current evidence suggests this is not consistently happening: only

¹¹ NHS England. Service specification: adult specialised services for people living with HIV. 2024. Available at: <https://www.england.nhs.uk/publication/adult-specialised-services-for-people-living-with-hiv/>

21% of ICBs reference HIV in their Joint Forward Plans, and just three mention specialised commissioning for HIV services or planning for delegation.¹²

- 4.5. It has been reported to the National AIDS Trust that, in several key areas, HIV care is not meeting the national service specification for adult specialised services or BHIVA Standards of Care. This highlights existing unwarranted variation across ICBs, which risks being further entrenched through delegation. Robust safeguards are therefore needed to ensure consistent delivery in line with national standards and guidance, alongside clear accountability to secure equitable, high-quality care regardless of geography.
- 4.6. As highlighted in the consultation response from the Specialised Healthcare Alliance (SHCA)¹³, it is also unclear who will be responsible for specialised commissioning clinical audits, databases and registries.
- 4.7. To ensure that ICBs provide locally informed, person-centred, equitable care for people living with HIV that meets their holistic needs, The National AIDS Trust supports the recommendation from the SHCA for the Committee to consider:
 - 4.7.1. A new clause requiring the Secretary of State to carry out a detailed impact assessment before any further delegation of specialised services takes effect. This should consider the implications of transferring full accountability from NHSE to ICBs, alongside the future of NHSE's wider responsibilities for specialised services.
 - 4.7.2. A new clause requiring the Secretary of State to produce and lay before Parliament an annual report on the performance of specialised services, including compliance with national standards.
 - 4.7.3. A new clause requiring the Secretary of State to ensure the regular publication of data on specialised services, such as the information on quality and outcomes currently captured within SSQDs

5. Mental health needs of people living with HIV

- 5.1. People living with HIV in the UK have a 63% greater risk of being diagnosed with mental illness compared to people without HIV.¹⁴ 2 in 5 people living with HIV in the UK have been diagnosed with at least one mental health condition, substantially higher than in the English general population.¹⁵ Despite this, mental health support for people living with HIV is often poorly integrated into HIV care pathways, difficult to access in a timely way, and not tailored to the specific experiences of living with HIV.
- 5.2. Provision of psychological support within HIV services varies significantly across England. While the Standards of Psychological Support for Adults

¹² https://cdn.prod.website-files.com/6682c2b63024dc5fac17ec7d/685d568d0e168a704ad6e8df_Bridging%20the%20Gap%20in%20HIV%20Care%20_%20a%20report%20by%20ViiV%20Healthcare.pdf

¹³ Specialised Healthcare Alliance (2026) Health Bill call for evidence: Submission from the Specialised Healthcare Alliance. Available at: <https://bills.parliament.uk/publications/66902/documents/8495>

¹⁴ <https://www.aidsmap.com/news/jun-2022/people-living-hiv-uk-have-increased-risk-mental-illness>

¹⁵ <https://www.gov.uk/government/publications/hiv-positive-voices-survey/positive-voices-2022-survey-report>

Living with HIV¹⁶ set clear expectations for integrated, ‘matched care’ within HIV pathways, many services lack the resources and workforce to implement them fully. This means that in some areas, people benefit from embedded psychological support within HIV clinics while in others, people must rely on generic mental health services with limited HIV expertise and potentially stigmatising treatment, long waiting times, and limited referral pathways.

- 5.3. HIV VCSE organisations provides essential psychosocial support, including counselling, peer support, and support addressing wider determinants of mental health such as housing and employment. These services are particularly important for improving wellbeing and preventing mental health conditions among those who do not meet thresholds for NHS mental health services. However, as highlighted in research from HIV Outcomes UK¹⁷, provision is increasingly fragile due to short-term and declining funding, leading to reduced capacity and, in some areas, the loss of critical services. This undermines prevention, early intervention, and sustained engagement in care.
- 5.4. Addressing mental health needs requires sustained, targeted investment. While the National AIDS Trust welcomes the Mental Health Investment Standard, current funding and commissioning remain inadequate to deliver consistently integrated, high-quality care across England.
- 5.5. The National AIDS Trust supports the Health and Social Care Committee’s proposed amendment that the Mental Health Investment Standard (MHIS) should be a statutory requirement on ICBs.¹⁸ ICBs should use these increased resources to ensure that all HIV services meet the BHIVA Standards for Psychological Support, HIV training across mental health services is expanded, and referral pathways in the NHS to VCSE services like peer support are strengthened.

6. Single Patient Record

- 6.1. The development of a Single Patient Record has the potential to significantly improve care coordination, safety, and patient experience for people living with HIV, particularly given that around two-thirds living with the virus in the UK have at least one additional long-term condition and often navigate multiple, fragmented services.¹⁹
- 6.2. Better integration of data across primary care, specialist HIV services, mental health, and wider support services could enable:
 - 6.2.1. more coordinated, multidisciplinary care.
 - 6.2.2. support shared decision-making and self-management.
 - 6.2.3. support personalised care planning accessible through the NHS App.

¹⁶ BHIVA (2025) Standards of Psychological Support for Adults Living with HIV. Available at: <https://bhiva.org/clinical-standards/standards-for-psychological-support/>

¹⁷ National AIDS Trust (2025) HIV Services at the crossroads. Available at: <https://nat.org.uk/publications/hiv-services-voluntary-sector-crossroads-crisis-report/>

¹⁸ Health and Social Care Committee (2026) Health Bill 2026-2027. Available at: <https://committees.parliament.uk/publications/53577/documents/299136/default/>

¹⁹ UK Health Security Agency (2024) Positive Voices 2022: survey report. Available at: <https://www.gov.uk/government/publications/hiv-positive-voices-survey/positive-voices-2022-survey-report>

- 6.3. However, HIV remains a stigmatised condition, and trust, confidentiality, and patient control must be central to the implementation of the Single Patient Record. In 2022, one in fourteen people living with HIV reported avoiding healthcare services due to concerns about stigma²⁰, underscoring the risk that expanded data sharing - if not carefully designed with co-creation with patients and healthcare providers - could further deter engagement with care.
- 6.4. The National AIDS Trust recommends that the Government should develop the single patient record with confidentiality and agency at the centre, ensuring that people living with HIV have confidence and trust in who has access to their data, choice in how and where it is shared, and agency over their own data. Therefore, the National AIDS Trust supports Amendment NC6²¹ to introduce a Health Data Charter which would include establishing clear principles for data sharing, patient control and opt-out options.
- 6.5. In addition, increasing data sharing without addressing stigma risks exacerbating existing inequalities. Therefore investment must therefore accompany digital reform to expand HIV training and stigma reduction initiatives (such as HIV Confident²²) across the health system to ensure all providers can deliver safe, competent, and non-discriminatory care.

7. Health inequalities

- 7.1. The inclusion of a Health Inequalities clause in the Bill is a welcome step. However, there is a clear opportunity to strengthen it further to ensure it can fully support the Government's ambition to reduce health inequalities, including those within the HIV response.
- 7.2. Ending new HIV transmissions and improving quality of life for people living with HIV cannot be achieved through healthcare services alone. Health outcomes are shaped by the wider social, economic and structural conditions that determine whether people are able to protect their health, access services, and remain engaged in care.
- 7.3. Poverty, insecure housing, discrimination, immigration status, and access to education and employment all directly influence a person's ability to engage with HIV prevention, testing and treatment. These factors also underpin wider population health outcomes and drive the stark inequalities seen across England, where people living in the most deprived areas experience significantly worse health and shorter healthy life expectancy than those in the least deprived areas.
- 7.4. Clause 4 as currently drafted focuses primarily on the role of the health system. While this is important, it does not sufficiently reflect the cross-government action required to address the root causes of health inequalities. Responsibility for tackling these inequalities must be shared across Government. Departments responsible for housing, social security, education, employment, justice and immigration all play a critical role in shaping the conditions that determine whether people are able to engage with healthcare

²⁰ *ibid*

²¹ House of Commons (2026) Health Bill. Available at: https://publications.parliament.uk/pa/bills/cbill/59-02/0008/amend/health_day_pbc_0625.pdf

²² <https://www.hivconfident.org.uk/>

and maintain good health. A cross-government approach is essential to the HIV response, as barriers such as poverty, insecure housing, stigma and immigration status limit access to testing, prevention and care. Health services alone cannot reduce inequalities and achieve the goal of ending new HIV transmissions.

- 7.5. Without a cross-Government statutory framework, there is a risk that action remains siloed within the Department of Health and Social Care, structural drivers of poor health remain unaddressed and progress towards national targets - including ending new HIV transmissions by 2030 - is undermined.
- 7.6. The National AIDS Trust therefore supports the amendments proposed by Health Equals²³ for:
 - 7.6.1. A stronger health improvement and inequalities duty to reflect the wider, cross-government goals for health improvement and health inequalities.
 - 7.6.2. A commitment to bring forward a Health Improvement and Inequalities Strategy that would include a requirement to set long-term targets for health improvement and inequalities, public reporting against the delivery of the strategy and progress towards the targets, and a duty on Ministers across departments to have regard to the health improvement.
- 7.7. These amendments would create a more robust framework to tackle the root causes of health inequalities and embed responsibility for improving health across Government. By addressing the structural barriers that restrict access to HIV prevention, testing, treatment and support, a strengthened statutory approach would help support the Government's target to ending new HIV transmissions and improving the quality of life for people living with HIV.

²³ UK Parliament (2026) Written evidence submitted by Health Equals to the House of Commons Bill Committee on the Health Bill 2026. Available at: <https://publications.parliament.uk/pa/cm5902/cmpublic/Health/memo/HB33.htm>