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Public Bill Committee

HEALTH AND CARE BILL

Sixth Sitting

Tuesday 14 September 2021

(Afternoon)

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Saturday 18 September 2021

The Committee consisted of the following Members:

Chairs: Mr Peter Bone, † Julie Elliott, Steve McCabe, Mrs Sheryll Murray

† Argar, Edward *(Minister for Health)*
Churchill, Jo *(Parliamentary Under-Secretary of State for Health and Social Care)*
† Crosbie, Virginia *(Ynys Môn)* (Con)
† Davies, Gareth *(Grantham and Stamford)* (Con)
† Davies, Dr James *(Vale of Clwyd)* (Con)
Foy, Mary Kelly *(City of Durham)* (Lab)
† Gideon, Jo *(Stoke-on-Trent Central)* (Con)
† Madders, Justin *(Ellesmere Port and Neston)* (Lab)
† Norris, Alex *(Nottingham North)* (Lab/Co-op)
† Owen, Sarah *(Luton North)* (Lab)
† Robinson, Mary *(Cheadle)* (Con)
† Skidmore, Chris *(Kingswood)* (Con)
† Smyth, Karin *(Bristol South)* (Lab)
† Throup, Maggie *(Lord Commissioner of Her Majesty's Treasury)*
† Timpson, Edward *(Eddisbury)* (Con)
† Whitford, Dr Philippa *(Central Ayrshire)* (SNP)
† Williams, Hywel *(Arfon)* (PC)

Huw Yardley, Sarah Ioannou, *Committee Clerks*

† attended the Committee

Public Bill Committee

Tuesday 14 September 2021

(Afternoon)

[Julie Elliott *in the Chair*]

Health and Care Bill

Clause 5

Public involvement: carers and representatives

2 pm

Question (this day) again proposed, That the clause stand part of the Bill.

Justin Madders (Ellesmere Port and Neston) (Lab): It is a pleasure to see you in the Chair this afternoon, Ms Elliott.

We were left on a cliffhanger before lunch. I was about to ask the Minister some questions. He might have preferred the advantage of having two and a half hours in between to think of an answer, but I am sure he will cope. Actually, it is a fairly straightforward question, so I hope for a fairly straightforward answer.

The clause refers to carers and their representatives. Will the Minister clarify who that is? Is that carers' groups or, for example, someone who might hold power of attorney? That is really the only comment I wanted to make on clause 5.

The Minister for Health (Edward Argar): It is a pleasure to serve under your chairmanship, Ms Elliott, I think for the first time in Committee.

To answer the shadow Minister briefly, I certainly envisage that the clause encompasses those with power of attorney, because in effect and in law they are the legal representatives of individuals who do not always have capacity to speak for themselves. In that context, I also hope that we will see carers' organisations, as well as others who do not necessarily have power of attorney but act as advocates or representatives for individuals, having their views heard and taken into consideration. I hope that gives the hon. Gentleman some reassurance.

Question put and agreed to.

Clause 5 ordered to stand part of the Bill.

Clause 6

Support and assistance by NHS England

Question proposed, That the clause stand part of the Bill.

Edward Argar: The clause confers a power to provide assistance and support to NHS foundation trusts, NHS trusts and other persons providing services as part of the health service in England to work to secure continuous improvement in the quality of the provision of such health services and their financial sustainability. That new power replaces a range of existing support functions sitting with NHS England and the NHS Trust Development Authority. In particular, it replaces the function of the NHS Trust Development Authority to take steps to assist health service providers as conferred by directions. It also replaces the existing power of NHS England to support clinical commissioning groups and primary care providers, which enables NHS England to provide direct financial support to integrated care boards and providers within the scope of the provisions, and to provide other support and assistance to all those bodies exercising functions within or part of the health service.

The clause is an example of the positive improvement that the merger of NHS England, Monitor and the NHS Trust Development Authority will bring to the health service. It will allow NHS England to take such steps as it sees as necessary to identify and address areas of concern early, while also providing support to leadership and guidance where required to shape the services that are delivered for the greatest benefit of patients. I therefore commend the clause to the Committee.

Justin Madders: The Opposition will not oppose the clause, but I have one or two queries that we hope the Minister will be able to answer. Obviously, it is a broad power. I assume that the reference in proposed new section 13YA(1)(a) to "person" relates not just to individuals. Perhaps the Minister will expand on what that is meant to cover.

Also, specifically, at proposed new subsection (3), on integrated care boards and the provision of financial assistance, as we remember from the evidence sessions, there was not a great deal of clarity about the costs that NHS England anticipated might be incurred as a result of the legislation. Will the Minister assist us by providing some estimates of that, as well as whether the powers under clause 6, including the financial assistance, are subject to any limits or reporting requirements back to the Secretary of State, and whether Parliament would have a role in that at any point?

Proposed new subsection (2) talks about providing

"employees or any other resources of NHS England."

The Minister said that "employees" could include secondees. I think it is clear from the guidance that certain roles on the ICB should not have any, for want of a better description, conflicts of interest or hold any other roles within the wider NHS. I want to make sure that the Minister is clear that that requirement is not going to cause us any difficulties.

Edward Argar: I am grateful, as ever, to the shadow Minister for his succinct questions. I will try to address them all in turn. He referenced the term "person" in proposed new subsection (1). It is a legal definition. In the context of the services provided—I mentioned primary care—it could be a GP practice. Having gone through the drafting with officials, my understanding is that it is a legal term and does not alter what is currently possible.

I may take the questions slightly out of order, and I hope he will forgive me. On proposed new subsection (2), I think he was referring to subsequent new clauses and amendments he has tabled around ICBs, who the suitable persons to sit on them are and the management of conflicts of interest. I suggest to him that, given the amendments he has tabled, the most appropriate time

to discuss those issues would be in the context of how we do or do not further refine the definitions around memberships of ICBs. The Committee will reach that on Thursday, I suspect. On reporting and transparency, I entirely share his view and reassure him that I expect transparency to play a key role when public moneys are spent this way.

Finally, on proposed new subsection (3) and the cost to the NHS and the Exchequer, no specific limits are stated in the legislation, but, obviously, any assistance provided would need to meet the purpose set out in the Bill and be transparently awarded. I hope that gives him some reassurance, but I am always happy to revert to him if he wishes to follow up on any detail—either now or in writing.

Question put and agreed to.

Clause 6 accordingly agreed to stand part of the Bill.

Clause 7

EXERCISE OF FUNCTIONS RELATING TO PROVISION OF SERVICES

Question proposed, That the clause stand part of the Bill.

Edward Argar: I am getting my exercise today in bouncing up and down in my seat. Clause 7 enables NHS England to direct one or more integrated care boards to exercise certain NHS England functions and to fund the exercise of those functions. This relates to NHS England functions such as the commissioning of specialised services, health services in justice settings and armed forces settings, primary medical services, dental services, primary ophthalmic services, pharmaceutical services, and any of the Secretary of State's public health functions that are exercisable by NHS England on his behalf. In future the intention is that ICBs be responsible for the majority of health service commissioning in England. This approach will ensure that decisions about services are made closer to the patient and in line with local population needs, enabling greater integration in the way that services are arranged and delivered.

Clause 7 ensures that NHS England has the appropriate powers to make sure we achieve our policy objective, by allowing flexibility for ICBs to take on these additional commissioning responsibilities as delegated functions from NHS England. We intend that this can be used by NHS England to delegate primary care functions while ICBs mature, before we transfer them fully to ICBs at the appropriate time using clause 16 and schedule 3, which we will debate in due course. This will allow NHS England to keep a closer watch on how ICBs are discharging these functions, and managing the transition, before they are fully delegated to and embedded in ICBs.

The Secretary of State will have the ability to make regulations under this clause, meaning that, where appropriate, certain conditions or limitations can be placed on NHS England's power to direct ICBs, including the ability to prescribe functions that the power does not apply to at all. Any directions issued by NHS England under this clause must be published. I know that the transparency point is one that the shadow Minister has raised on a number of occasions, so I reassure him that they must be published ensuring that such directions are made transparently, and that responsibilities between NHS England and ICBs are clearly set out.

This clause is essential to give NHS England the flexibility, and the appropriate mechanisms, to delegate the commissioning of these services when the time is right to do so. Therefore, I commend it to the Committee.

Justin Madders: We will not be opposing this clause. Clearly, as the Minister has set out, it is necessary to enable the functioning of the health service.

I have one question about the powers under proposed new subsection 13YB(4), which are effectively prohibitions on the ICBs from delegating arrangements further. Will the Minister set out what circumstances are envisaged, if any, where this power may be necessary? There will obviously be delegations, not only to the services listed there, but to place-based organisations. In that situation, what does the Minister see the role of the ICBs as? Will it be the ICB itself that delivers those functions, or will it be another body?

Karin Smyth (Bristol South) (Lab): Further to those points about clarity around the exercising of powers, the move to give NHS England that power is entirely sensible. The medical, dental, ophthalmic and pharmaceutical services have had a lower profile in our constituencies over the last few years, as I think we would all agree. It is important to give them the profile they need to be integrated into the system, because they have certainly not been so far.

The evolution of delegating that power to CCGs came late in the day, and remains muddled around the commissioning of primary care services. Therefore, while allowing the delegation of function is entirely sensible, it is not clear, as my hon. Friend the Member for Ellesmere Port and Neston has said, when or how that delegation will be sought. I think the Minister was referring to the involvement of the Secretary of State, but I am not sure in what circumstances the Secretary of State would be doing that, and why this would not be when NHS England, or NHS England regions, decides that the ICB is of a maturity to accept commissioning responsibilities.

One assumes that NHS England believes that at the moment some of those putative organisations are mature enough already; will some of them start doing that on day one, six months in or a year in? How will we know and how will they be resourced to do it? Is it a transfer of power? How NHS England and the local ICB, without representatives of medical, dental, ophthalmic and pharmaceutical bodies, will be taking that on board is all very opaque.

Alex Norris (Nottingham North) (Lab/Co-op): My hon. Friend has a local Mayor, but my community does not. If someone lives in Greater Manchester there is a Mayor, but in other places there may not be. We have a very asymmetric model of local devolution. Does she agree that an asymmetric model of devolution, where some ICBs had certain powers and others did not, would be undesirable and may create more confusion than it solves?

Karin Smyth: My hon. Friend makes an interesting point about asymmetrical power and who does what. I may differ slightly, in that I think that that may suit local circumstances, but the judgment about what a mature ICB is, and which powers it should be responsible for, has been made behind closed doors and according to criteria about which we know nothing. The professionals in those services certainly deserve to know better.

2.15 pm

Fundamentally, however, patients in both our areas need to understand and know who is commissioning and why. The state of dentistry shocks us all as a nation, as do those of ophthalmic services and pharmaceutical services, which we know are so important for supporting the wider system. We want to ensure that those services thrive and that they are clear about how they are being commissioned and who is doing it.

In my experience, the evolution from the CCG was muddled and meant stasis for a long time in any development of those services. We want to avoid that, because some of those organisations will be ready to go now and some of them may never be ready. As my hon. Friend says, is that an acceptable position for the Government in this new area of local permissiveness?

Edward Argar: The hon. Lady is absolutely right about the importance of trying to join up different primary care services and the commissioning arrangements. There has been, under Governments of all complexions, a fragmentation in that, with some services commissioned nationally and others locally, and the Bill gives us an opportunity to create a more coherent, place-based commissioning approach.

On the specific point the shadow Minister asked about proposed new subsection (4) and the

"direction under subsection (1) to include provision prohibiting or restricting the integrated care board from making delegation arrangements in relation to a function that is exercisable by it by virtue of the direction",

my understanding is that it is a pragmatic clause, basically limiting the ability to sub-delegate further. We would envisage this being a consensual and collaborative approach between us and NHS England in the region, and of course the Government would be guided by NHS England.

In the nature of having to make regulations in this House to do it, the wording reflects the fact that it will be the Government laying those regulations, but we would envisage that being guided and led by the NHS. As the hon. Member for Bristol South rightly said, the NHS region will often be the best place to advise on the readiness or otherwise of different ICBs at different stages in the process.

Karin Smyth: Would somebody be able to appeal to the Secretary of State if they disagreed with that delegation, for example?

Edward Argar: My understanding is that there is no formal right of appeal in this context. I suspect that dispute resolution and formal rights of appeal is something we will come back to in other contexts.

Clause 7 ordered to stand part of the Bill.

Clause 8

PREPARATION OF CONSOLIDATED ACCOUNTS FOR PROVIDERS

Question proposed, That the clause stand part of the Bill.

Edward Argar: Clause 8 places a duty on NHS England to prepare, in respect of each financial year, a set of accounts that consolidate the annual accounts of English NHS trusts and foundation trusts. The transparency of financial reporting across NHS providers will be diminished without this provision, as the consolidated provider accounts collate the financial reporting of all NHS trusts and foundation trusts to give an NHS provider position that is laid before Parliament, and has been since the 2017-18 financial year.

In addition, NHS England has a duty to provide a copy of the consolidated accounts to the Secretary of State and the Comptroller and Auditor General, and a duty to lay copies of the consolidated accounts and the related report before Parliament. To ensure adequate financial scrutiny, the Secretary of State has the power to give directions to NHS England on the principles and methods to be applied in preparing the accounts and their content and form, and can direct that the accounts must be accompanied by any reports or information deemed necessary. The Comptroller and Auditor General must, as their responsibilities stand currently, examine, certify and report on the consolidated accounts and send copies of the report to the Secretary of State and to NHS England.

The provisions set out in this clause not only provide continuity to the system but place in law strong levels of oversight relating to both NHS trusts and foundation trusts. That ensures the transparency that we would all wish to see and the robustness of the process and procedures governing financial health at a local level. This clause is an important way of ensuring NHS England discharges its responsibilities as system regulator in delivering appropriate and adequate stewardship of the health system and, ultimately, public money.

Justin Madders: Again, we will not oppose the clause, but I have a query about the powers under proposed new section 65Z4(4), particularly in the context of what the Secretary of State said at the weekend about targets being a lot of form-filling and nonsense. It seems rather odd to give himself powers to direct trusts to provide any reports or information that he requires when, clearly, the Secretary of State gets all sorts of information and reports from the NHS at the moment. Could the Minister say what he is not receiving at the moment that he thinks the powers will allow him to ask for?

Edward Argar: I consider proposed new subsection (4) to be purely pragmatic, as there will be circumstances with individual trusts and situations where clarifications to accounts or data may be required. Therefore, it is prudent to give the Secretary of State the power to ask for further clarification. He will be accountable to Parliament for how the money is spent, so it is entirely appropriate that he has explicit power, given by Parliament, to ask for information over and above the de minimis specified in the Bill, to ensure he can be completely transparent with Members and the public more broadly.

Question put and agreed to.

Clause 8 accordingly ordered to stand part of the Bill.

Clause 9

FUNDING FOR SERVICE INTEGRATION

Question proposed, That the clause stand part of the Bill.

Edward Argar: Currently, one of the objectives of the Government's mandate to NHS England—a process we discussed in Committee this morning—is that an amount of the annual sum paid to NHS England must be used for service integration. In practice, that must be contributed to the better care fund. The better care fund is the national policy driving forward the integration of health and social care in England. However, as we have discussed, other provisions set out in clause 3 will remove the requirement for a mandate to be published every year. As a result, the mandate will no longer be an appropriate vehicle for setting an annual ring fence for service integration. Therefore, the clause will put in place a new power to allow the Secretary of State to direct NHS England to ring-fence an amount of its annual allotment for health and social care integration through the better care fund, to continue the work of that fund and to direct it on how that amount should be used.

The change will have no impact on the operational policy intent of the better care fund; the provision will simply ensure the better care fund can continue to be set annually, notwithstanding changes to the mandate, which will not be made annually in the future, should this legislation be passed. The better care fund has enabled and improved co-operation between health and social care partners at local level. It is therefore important for it to continue. This clause ensures that that will happen, regardless of proposed changes to the mandate.

Further minor amendments are made to NHS England's corresponding power to enable it to require that an amount of the sum paid each year to an integrated care board be used for service integration. That power exists currently in relation to clinical commissioning groups, and the amendment seeks to ensure that the better care fund continues to operate effectively once ICBs are established.

Justin Madders: Again, I will not detain the Committee for long: I just have a question for the Minister. The more we get into the Bill, the less permissive it appears to be. I have no doubt that will still be used by the Minister in defence against various amendments we will move later today. Given that we have been told that the role of ICBs is to direct health systems in their local areas, it is not at all clear what the situation is if the powers under this clause require them to set aside a certain amount of money for service integration, but doing so would mean a reduction in service elsewhere in the system. How would that dispute be resolved? Who would have the final say?

Edward Argar: As I made clear in my remarks, the clause does not so much direct ICBs specifically; it is primarily about setting aside an amount of the annual sum paid to NHS England to go to the better care fund, which is then allocated. This technical change will have no impact on the operation or policy intention of the BCF, and it should not have an impact on ICBs' ability to operate. The intention is simply to make sure that as we move away from an annual mandate with an annual financial settlement for the BCF, we can still set an annual amount to go to the BCF so that it can continue its work, and for that to then be allocated to systems.

Question put and agreed to.

Clause 9 accordingly ordered to stand part of the Bill.

Clause 10

PAYMENTS IN RESPECT OF QUALITY

Question proposed, That the clause stand part of the Bill.

Edward Argar: The clause removes the Secretary of State's powers to make regulations about payments by NHS England to CCGs in respect of quality. We are not abolishing quality payments, but in future they will be made to integrated care boards rather than CCGs—hence the change. However, the current clause conflicts with clause 37—General power to direct NHS England—which provides the Secretary of State with broad powers to give directions to NHS England. Clause 10 removes the power to make regulations setting out the principles or other matters that NHS England must consider in assessing any facts in relation to payments to a clinical commissioning group. However, clause 37 will allow the Secretary of State to use the general power to direct NHS England if required, including in relation to quality account. That will give additional flexibility to shape quality payments in order to better incentivise quality, reflecting our priorities and changing circumstances.

I reassure the Committee—I am not sure whether the shadow Minister will take the reassurance, but he may do—that there is no intention to use these powers frequently, but they will ensure that we have a robust legislative framework that is flexible and responsive enough to support the health and care system in future, in the event that such powers are needed. If Ministers were to direct NHS England in this area, they would be required to do so in writing, ensuring that the direction is in the public interest, and to publish that direction. That will ensure transparency, so that Ministers can be held to account. I suspect that we might return more broadly to that underpinning principle when we come to debate further clauses relating to it in the coming days. I commend the clause to the Committee.

Question put and agreed to.

Clause 10 accordingly ordered to stand part of the Bill.

Clause 11

SECONDMENTS TO NHS ENGLAND

Question proposed, That the clause stand part of the Bill.

Edward Argar: I have only a couple more of these clauses before the shadow Minister will have his turn with a few amendments.

Secondments can be an extremely useful way of bringing key expertise and resource into an organisation at short notice. We have seen the benefits of such a flexible approach in a number of organisations, including NHS England, and particularly during the pandemic. The

[Edward Argar]

clause builds on the practical importance of secondments and makes it clear how they can be used by NHS England, by amending schedule A1 of the National Health Service Act 2006, which sets out the constitution and membership of NHS England.

The Bill has given us an opportunity to provide NHS England with powers to appoint secondees across the organisation and use them in the same way as its own employees, and it allows secondees from specified NHS bodies and health arm's length bodies to be appointed to NHS England's board. The power to allow employees from specified NHS bodies to be seconded to NHS England and appointed to its board will allow those individuals to exercise NHS England's functions on the board's behalf, in the same way as other board members.

As we continue the fight against the covid-19 pandemic and, in parallel, prepare for the recovery of our health and care system, it is imperative that NHS England has access to the most suitably experienced and knowledgeable candidates for executive roles, and that those holding the roles be part of the important decisions that the system will face. The clause will assist NHS England in doing just that.

The clause also includes a regulation-making power, allowing the Secretary of State to make it clear that a reference to an employee of NHS England in the context of the National Health Service Act 2006 should include people seconded to NHS England, should that be considered appropriate in future. That power will ensure that the legislation assesses the continued effect of operation of secondment arrangements throughout NHS England. Any regulations—again, I hope that this offers some reassurance to the Opposition Front Bench—made under that power would be subject to the affirmative procedure in the House, so I commend the clause to the Committee.

2.30 pm

Justin Madders: I will not repeat my earlier comments about secondees and ICBs, because we will pick that up later. In our evidence sessions, the role of the healthcare safety investigation body and its independence from NHS England was raised. Is the Minister comfortable that that role will not be compromised in any way by the requirements of the clause?

Edward Argar: I assume—and the hon. Gentleman will probably shake or nod his head—that in this context he is referring both to the Care Quality Commission and HSIB—*[Interruption.]* Yes, I am reassured and confident that the provisions in clause 11 will not impact negatively in any way on the ability of either safety organisation to conduct inspections and do the work that we envisage them doing. In the case of HSIB, we may return to that when we discuss the relevant clauses. I believe that what is proposed remains consistent with their specific roles, responsibilities and obligations and what we are seeking to achieve for patient safety.

Question put and agreed to.

Clause 11 accordingly ordered to stand part of the Bill.

Clause 12

ROLE OF INTEGRATED CARE BOARDS

Question proposed, That the clause stand part of the Bill.

Edward Argar: The clause replaces section 1l of the National Health Service Act 2006, which sets out the general function of clinical commissioning groups, with new section 1l, which sets out the general function of integrated care boards. It provides, in a similar way to CCGs, that ICBs have the function of arranging for the provision of services for the purposes of the health service in England. As a result, ICBs will now be the new commissioner responsible for the majority of health service commissioning in England. Later clauses will set out the details of the services that ICBs are responsible for commissioning, but we intend that they should include those currently commissioned by CCGs and some that are commissioned by NHS England, as we discussed in relation to a previous clause, such as primary care, dentistry, pharmacy and optometry services.

The clause is crucial to establish ICBs as the new key commissioners for the NHS in England in future. Our proposals bring together leadership across the health and care system, and without the clause ICBs will simply not have a clear purpose. It seeks to manage effectively in legislation the smooth transition from CCGs to ICBs, and I commend it to the Committee.

Justin Madders: Obviously, we will spend time this afternoon discussing ICBs, so I will not discuss this clause in particular. I will draw attention to proposed new section 14Z26, especially the proposals in subsections (2) and (3) for integrated care boards, which effectively allow clinical commissioning groups to determine their own processes to consult on ICBs. We do not think that the consultation process has been adequate—indeed, it has been non-existent in some situations—but we will probably return to the question of ICB geography later in this sitting.

Question put and agreed to.

Clause 12 accordingly ordered to stand part of the Bill.

Clause 13

ESTABLISHMENT OF INTEGRATED CARE BOARDS

Justin Madders: I beg to move amendment 49, in clause 13, page 8, line 34, after "board", insert

"NHS trust, NHS foundation trust, trade union, patient representatives and local authority".

This amendment would ensure that trusts and local authorities are consulted before any changes are made to the number, shape and size of ICSs.

There are two big themes on integrated care and the White Paper in the Bill and associated documents. Our points are aligned with those of local authorities, using the integrated care partnership as the vehicle to bring the planning of services, such as social care and housing, into the wider framework. It is also the development of the concept of place.

Local government, as we know, does place; the NHS probably does not do it in quite the same way. The clue is in the name. The "local" in local government means that it has always done community engagement; it already has to integrate multiple public services around the needs of a defined population. It is fair to say that the NHS has operated in a very different way in the past and can appear to have a different geography for every service that is accessed.

The Bill settles on 42 as the magic number of areas that the NHS is divided into, which could be influenced by "The Hitchhiker's Guide to the Galaxy" and the ultimate question about life, the universe and everything. That might make more sense than what has been put forward so far as the optimal configuration for the integration of services. The view of many of those who we have spoken to is that 42 is too many for the commissioning of most acute and tertiary services, and too big for the commissioning of primary and community services and social care. Like a lot of things, it is a compromise. It is a fudge. It is an accommodation between competing interests and views.

There is very little explanation in the Bill—in fact, we have zero explanation—about how place will work. We need to understand more about that from the Minister. How will place fit into the commissioning framework? I hope we can have some further guidance in the Minister's responses. For us, the concept of place is just that—a concept. It is not really pinned down or articulated clearly in the legislation.

As Members will be aware, the NHS has had local government as its key partner in healthcare from the outset. That is recognised by various bodies. For a long time, boundaries were not an issue. We sometimes forget just how intimately involved the NHS and local authorities were at the outset of the NHS. That has obviously changed over the years. It would be fair to say that the current integrated care system boundaries are really a product of the NHS and the way that they have been imposed implies a great weakness in the whole Bill. It is supposed to be about integration between local authorities and the NHS, but it is almost all about what the NHS wants and what it thinks is the best outcome. It should have been co-produced with local government, not presented as a fait accompli. Is the Minister able to tell us how much local authorities and mayoralties were involved and consulted in the design of ICS boundaries?

There is a dilemma here. In our view, starting this way, with boundaries that do not always reflect the natural communities that they are meant to serve, will store up problems. We are less than impressed by what has happened to date, and while we might well be stuck with the 42 configuration that we have now, that does not mean that we agree with the process. I use the term "process" in the loosest possible way. We do not believe it should be a template for the future. Amendment 49 seeks that, in future, any changes in ICS boundaries should be decided in consultation and conjunction with trade unions, local authorities and trusts, and that they are consulted before any further changes to the shape or size of ICSs are made.

The problem we see is how the big acute trusts fit into the system. It has been a problem faced in places such as Scotland and Norway, which are further down the integration pathway. As would be expected, the big trusts dominate, but while they might take 80% of the budget, the vast majority of interactions for the patient are in primary and community care and, of course, in social care. All of those sit far more comfortably in the local authority footprint, as the National Health Service Act 1946 accepted. It is even simpler to consider place in terms of districts and wards or even super-output areas. Those terms are all very familiar to local government, and local authorities already take them into account when they consider how to deliver their services. When the Pandora's box is opened, we assume place is aligned with something that has already been defined, and we do not try to invent yet another new geography, as has been attempted with ICSs.

I would like to hear from the Minister what the impact might be of further revisions to the boundaries. I understand that Ministers have looked at that and they have apparently changed some but not others, without publishing any real rationale. I note that there have been some cosy fireside chats, after which various changes have emerged. That reminds me of how the Conservative party used to anoint its leader, but it is hardly a transparent or open way to do things.

Let us do the job properly, transparently and openly. No ICS should have a boundary that has not been agreed with all the relevant local authorities. I have had some information from the Minister in reply to a written question about discussions that he has had with hon. and right hon. Members, and I am grateful for that. However, I am still waiting to see all the evidence and civil servants' recommendations that he had to hand when he made his decisions. One of the main themes during the evidence sessions was the concern that the Secretary of State and Ministers could make decisions for party political, or other less than noble, reasons. Of course, I do not accuse the Minister of doing that, but when decisions of this magnitude are taken in this manner, such questions will be asked.

Whenever we have changed the boundaries of parliamentary constituencies, there has been an extremely lengthy process. When my own local authority, Cheshire West and Chester, came into existence, I recall that regulations were approved by Parliament. I know that because I lived through the trauma of that change; for the record, I should state that my wife is a member of that local authority. The point is that the contrast between what happens with that sort administrative border change and what has happened here is stark. I should also make it clear that I have another hat on. As the Minister will know, there have been many discussions about the ICS area in Cheshire and Merseyside, and, as I understand it, the configuration will be reviewed within the next two years. I am sure that the hon. Member for Eddisbury agrees with me that any decision on that should be made with more transparency than we have seen to date, not less.

As an aside, it is probably worth saying that if we pretend that everything can be resolved on a single footprint, we fail to acknowledge that there are regional arms of what is pretty much a national ambulance service, some trusts operate multiple services across clinical commissioning groups, and even tertiary services are commissioned by NHS England for large population areas. Acute care will not be commissioned at place or even ICS level, so we need to think about a simple place-based model for the rest. In terms of transaction volumes, the vast majority of care services, and indeed wider public services such as education and housing, are already provided on a local authority footprint.

At this point, I will mention our proposals for elected chairs, which I will come to shortly. With the right boundaries, it would be a lot easier to enact that. Proper co-location brings healthcare into line with the rest of the public services—local authorities, police and fire. It makes no sense at all for ICS boundaries not to be coterminous, and I do not think the Minister should

[Justin Madders]

disagree with me on that. The boundaries need to match those of combined authorities and mayoralties, and they should be set by local authorities and their partners, not just by the NHS. In terms of transactional volume, the vast majority of patient care interactions are in primary, community and social care, and for the patient they are all classed as local.

This veers into a bigger debate about devolution, mayoralties and combined authorities. The trend is one way. If we start with a blank sheet of paper, the answer is obvious: align along existing populations and boundaries. This matter should have been discussed well before the switch from sustainability and transformation partnerships to ICSs; indeed, that should have been done when the STPs were formed. That was the time to develop a proper and open process and deal with concerns. That is history now, but at least with this amendment we may be able to avoid repeating those mistakes.

2.45 pm

Edward Timpson (Eddisbury) (Con): It is a pleasure to serve under your chairmanship on this Bill Committee, Ms Elliott. I rise to speak on the amendment, not to support it, I am afraid, but I do want to show some sympathy with the arguments the Opposition have raised about the way ICSs have come into being and particularly about their size and population.

As was hinted at by the shadow Minister, the hon. Member for Ellesmere Port and Neston, this is where we have a shared experience of the shadow integrated care system in Cheshire and Merseyside, which has, I think, been through four different leadership teams in the last five years. Concerns have been raised with us, by local government but also by many working in the health service in and around Cheshire and Merseyside, about how the construct of this ICS will impact on their ability to deliver local place-based healthcare.

On size, the majority of the evidence we have had in the sessions to date has suggested that the formulation of ICSs needs to have a level of flexibility and permissiveness. However, we also need to be cognisant of the fact that there are populations that will need to be served differently, based on past experiences of borders that already exist. Cheshire and Merseyside will to cover 2.6 million people—that is over eight times the size of some ICSs. It will incorporate 9 CCGs—more CCGs than that, but in Cheshire itself it has moved from four to one as recently as April 2020. There will be 19 NHS provider trusts and 51 primary care groups. It is going to be an almighty body trying to make sure we deliver healthcare at the very local level as best we can.

If that is not done well and there is not the right level of scrutiny, transparency and accountability, the number of bodies on the Cheshire and Merseyside board, for example, could end up being 63 if every body that falls within that geography and that has asked to be on it has a place at the table.

We contrast that with the example of Gloucestershire. We had evidence from Dame Gill Morgan, who is the chair of that ICS, which is one of the much smaller ICSs. In one of our evidence sessions, she was very clear from the experience that she had had:

> "If you have a really large ICS and you are trying to do it all, you are so distant from patients, citizens and clinicians that you will never have the contact. Place, in those bigger systems, has to be where you begin to pull those things together, by getting the right people to engage and developing the right level of trust."—[*Official Report, Health and Care Public Bill Committee,* 9 September 2021; c. 129, Q177.]

Where that will be vital in an area such as Cheshire and Merseyside is on my second point, around population. The ICS will incorporate a huge and diverse population across the Liverpool city region and Cheshire. Those who have only a cursory knowledge of that part of the world will not be surprised to hear that, within it, there are very different health populations, needs and inequalities. The concern that has been raised with myself and other local representatives is that, over time, there is a risk that that might have an impact on some of the priorities, and where they sit within that large area, as well as on what allocations that might bring to deliver the right level of healthcare.

In one of the unitary authorities in Cheshire—Cheshire East Council—somewhere between 55% and 70% of its overall budget is spent on social care. It is so important that these bodies have an integral role in making sure that the place-based services match what they know is needed within their own budget.

There has been some amelioration of that issue, by virtue of the local authority representation on the integrated care board—I think it has two representatives. I was pleased to see in my hon. Friend the Minister's written statement on 22 July that as part of the boundary review of the ICSs, which has been referred to, Cheshire and Merseyside will have a period of two years where the current arrangements will be reviewed. I seek assurance from the Minister that that review will have veracity and deep-rooted scrutiny of the performance of the ICS during that period, to ensure that it does not fall into the trap that some of the larger ICSs could do unless we have the balance right between the role of local government and local healthcare providers, alongside this larger organisation, which will have to encompass a huge range of demands and pressures on its time and resources.

I have every confidence that my hon. Friend will ensure that the exercise is fruitful, that in Cheshire and Merseyside—particularly in Eddisbury and in Ellesmere Port and Neston—we end up with a better system than we have, and that our patients and residents will be able to get the healthcare that they need when they need it, irrespective of where they live.

Dr Philippa Whitford (Central Ayrshire) (SNP): It is important to recognise the changes that the NHS in England has been through over the past 20 years, moving from about 100 strategic health authorities to primary care trusts, too more than 200 CCGs, to STPs and now to this. Witnesses in the ICS session said that although some were making great progress, it was those with boundary difficulties that were falling behind. The Bill talks about population health and wellbeing, but local government drives a lot of those things: housing, active transport, social care or what the town centre looks like. It is therefore important to get the boundaries right, or in a few years' time there will be yet another upheaval.

In Scotland we got rid of trusts and went to health boards in 2004, and we have had 17 years of stability since then. If people keep moving around who they are

connected with, the Government are breaking relationships and expecting people to form new ones. This is not a minor thing. I would like the Minister to explain what the basis was for deciding the number, the size and the geography of the boards. Was some formula used? Trying to get that right will be a major influencer of the outcome of the whole policy.

Karin Smyth: Ms Elliott, you were not with us last week when I bored the Committee about how many different jobs I had done in the NHS over the 20 years to which the hon. Member for Central Ayrshire referred. I feel as if I have lived and breathed that journey from the health authorities' commissioning function through to primary care groups and primary care trusts. Much like the hon. Lady, I was prompted to come into this place by the Lansley Act—the Health and Social Care Act 2012. We all knew on the ground that, as was warned of and as has now been shown, it was completely nonsensical. It was never going to work, and it was hugely detrimental to the progress of securing better health in an efficient and effective way—more so than anyone could have imagined. I came here in 2015 for a bit of a quieter life—that has gone well for me!

Locally, I objected to the geographical footprint—we do not want to get into the footprints, but they are important to local people. The Bristol, North Somerset and South Gloucestershire footprint makes no sense to anyone apart from the chief executives of the local trust, because it is about acute sector flows and absolutely nothing else. That is why it is disappointing that we have not, for example, added health inequalities to the triple aim, because that would force such bodies to look at something more than the bottom line of those large acute sector trusts.

Dr Whitford: On that issue, when one of the amendments was turned down earlier, the Minister suggested that there was already a responsibility to deal with health inequalities that sits within the NHS. Yet, after 70 or 80 years, we have failed to do that, so do we not need not such priorities in the Bill? They need to be taken into account in shaping the ICSs.

Karin Smyth: I completely agree and, as I said, in that sense it has been refreshing to talk to financial directors locally. People who go to be finance directors in NHS organisations have healthcare in their hearts—they want to see only good healthcare and good outcomes—and some of this forcing together of clinicians, finance directors and other managers to look at population health is welcome. They recognise that the way in which the current funding model works—we will come on to the tariff—often stops them doing that, so adding in health inequalities would help. For the moment, we have lost that argument in Committee, but we will see how we get on in future.

In essence, where we have got to now is large CCGs coming together. That is what they are: they are rebranded CCGs. The wording in the Bill has been cut and pasted from 2012. I have other words for describing them: they are an NHS cartel. The CCGs commission and the big providers in that group all decide locally how the NHS cake should be cut—we will come back to that in future amendments. They are accountable neither nationally nor locally. That is deeply problematic. Even the partnership bit, as I think we established last week, is a committee of the ICB, although the Minister may want to clarify that. Sir Robert Francis did question whether that was the case. That goes to show that the architecture is really unclear.

The ICBs are creatures of the NHS, and well done to it for getting that on the statute book—almost—but this is essentially the same model. Therefore, as the hon. Member for Central Ayrshire alluded to in talking about the past 70-odd years, we need something better. The danger is that, as before, these bodies have no real discretion over spending; mostly, they are just the conduit for payments to existing providers. There is no real clout or sight of where we develop new services. They have very few levers to pull to drive innovation or service improvement.

All Members should be concerned about how we get that innovation and how we drive service improvement into the system. We need the ICBs to be better. They need to attract and retain the highest quality management or they will fail. They need to be perceived by the public as relevant and they need visibility. They must be the place where ambitious managers seek to work. They have to be the powerhouses, because they are the controllers of the money. They need good managers if they are to have an impact. They need to have local relevance—we will come back to that in future amendments. I am keen to support the amendment tabled by my hon. Friend the Member for Ellesmere Port and Neston about elected chairs and non-executive directors. Being held to account by the NHS region is very unhelpful.

In relation to Healthwatch, Sir Robert Francis—we should certainly take note of someone of his stature—told us the other day:

> "All organisations currently in the NHS have directors of engagement and communication. I suspect that, with the best will in the world, most of them see it as their job to defend the organisation. This is not about defending an organisation; it is about welcoming constructive comment from the public and responding to the needs that people communicate to them."—[*Official Report, Health and Care Public Bill Committee,* 9 September 2021; c. 150, Q212.]

We can disagree on how that happens, but some of our amendments are designed to help that happen. This cartel is deeply problematic for all hon. Members locally.

As commissioner organisations, accountability does matter. No one is going to walk down the street saying, "Save my CCG" or "Save my ICB" while carrying a banner to save their local hospital. But CCGs control over £75 billion of taxpayers' money, and they will continue to spend that sort of money. In my area, it is upwards of £1.5 billion or £2 billion. That dwarfs the council's budget; it totally dwarfs the police's budgets, yet we allow it to be done in this way. Even as a Member of Parliament with 20-odd years in the health service, I have sometimes found it almost impossible to find out who is accountable when a constituent comes to me with a particular issue. That is why I have focused on accountability and good governance.

In the proposed new organisations, who will be hauled up when something goes wrong? Who reports to the Public Accounts Committee? If the budget is inadequate, who decides what is cut and what is closed? If the boards are making those kinds of decisions, we need to know who appoints them. How do we know that they are independent? How can we remove them if they do

[Karin Smyth]

not perform? If big decisions are planned, how do we know? What restrictions, if any, should constrain our right to know? The Bill should spell out those things. All our witnesses, and reams of written evidence, are grappling with that issue.

Politically we might disagree with the centralisation of the NHS and the diktat as opposed to the permissiveness. I am definitely on the more localised, permissive side. I think we need good managers and good clinicians to lead and develop our health services and to be accountable for that money. They must be really accountable.

I hope that in his reply, the Minister will take the opportunity to push back on some of the negative language about administrators and managers in the health service. There is a very good article in *The Spectator*. I commend it to him, if he has not read it. Why would we have doctors and senior consultants on the phone to these 5 million patients, trying to reschedule their appointments? Who is going to go and fix the boiler? The list goes on and on. We need to make these organisations the beacon of good quality management.

3 pm

We need to thank the managers for the way they have worked, particularly over the pandemic. They have managed to go to extraordinary lengths to develop services. It does the Government and other politicians no credit not to recognise that, if the boards are going to work, they are going to need highly skilled people to balance all the competing interests and to make the best use of permissiveness. I think the Government are probably envisaging that they can just hand the mess over to them, but someone is going to have to make it come together locally. As local representatives, we are going to want to go and talk to somebody and to be able to hold them to account on behalf of our constituents. That is what we are seeking to do with further amendments today, and later in the Committee.

Edward Argar: I am grateful to hon. Members for their contributions on the amendment. I may disappoint the shadow Minister—I will not accept it. I hope he will let me address why and deal with some of the questions that have been raised.

The amendment would place a requirement on NHS England to consult relevant NHS trusts, foundation trusts, trade unions, patient representatives and local authorities before revoking or varying an ICB's establishment order. We consider it unnecessary, because under clause 13, proposed new section 14Z25, NHS England is already required to consult any integrated care board that is likely to be affected before varying or revoking an integrated care board's establishment order. Given that each ICB will have a strategic view of the health service and population needs in its area, and given that ICBs will have members from different NHS trusts and local authorities, we consider that they remain the best-placed bodies to bring those views together to reflect opinion on what is an appropriate boundary or establishment area.

Section 13Q of the NHS Act 2006 already places a duty on NHS England to involve and consult the public in the planning of commissioning arrangements, including in respect of any planned changes to commissioning arrangements. That includes, for example, if NHS England plans to change the range of health services available to the public or the manner in which they are delivered. That ensures the voices of residents and patients—those who access care and support—as well as their carers are properly embedded in decision making.

I draw the Committee's attention to the requirement in clause 13, proposed new section 14Z26, for CCGs to consult any person they consider as appropriate on the first ICB constitution. That constitution will also be required to set out the process for making further amendments to the constitution.

Turning to the points raised by the shadow Minister and other hon. Members, the boundaries on which we are seeing the footprint put forward at the moment effectively reflect the evolution of STP and ICS boundaries to this point. They reflect local authority boundaries. By and large, the majority of ICS boundaries reflect one or more upper-tier local authorities. That was the criteria set by the Secretary of State. There are some exceptions, which I will turn to in a moment. I will also turn to the comments from my hon. Friend the Member for Eddisbury.

As the shadow Minister will be aware, the previous Secretary of State set out a process where he wanted a presumption in favour of coterminosity—the shadow Minister appeared to be supportive of that—unless there were exceptional circumstances in a particular area that justified an exception being made. The principle of coterminosity is something that was argued against, in some cases, by Opposition Members—not Front Bench spokespeople, as far as I am aware, but Back-Bench Members of Parliament—and by some Government Members, in respect of where there should be specific exceptions.

The process, which was touched on, was entirely consultative. Local authorities were fully involved in those discussions. The local NHS was fully involved in the discussions. There were also what could be referred to as cosy fireside meetings, involving Members from across the House, reflecting their right as Members of Parliament representing their communities to write to and engage with Ministers, to reflect their views. There was a multi-layered approach, with the local NHS and local authorities working together to come up with recommendations, and then Members of Parliament having the right, as all Members do, to lobby Ministers and put forward their perspective on behalf of their constituents. The approach was transparent, as my hon. Friend the Member for Eddisbury alluded to. We published a written ministerial statement, setting out for the House what had been decided, and we showed the flexibility and pragmatism that I think those consulted would wish to see.

In the areas where exceptions were made—the east of England areas and Frimley—contrary to what the hon. Member for Bristol South said, these are some of the most exceptionally high-performing ICS areas. That is one of the reasons why we decided not to go for coterminosity, because those systems are working well, with established relationships with local authorities, acute trusts and primary care. We took the view that we should not disrupt something that is working well—if it ain't broke, don't fix it. That will not stop it being

reviewed in future, should the local system feel that that would be appropriate. That was a pragmatic approach to the issue.

My hon. Friend the Member for Eddisbury raised the issue of Cheshire and Merseyside ICS—I know that this will also be of interest to the hon. Member for Ellesmere Port and Neston, given the geography of his constituency. The ICS did meet the coterminosity test of one or more upper-tier authorities being coterminous, but I know that hon. Members on both sides of the House have raised concerns about its size and about the differences between Cheshire and Merseyside proper, and between different parts of the area, and suggested whether it should more appropriately be split into a larger number of smaller coterminous ICSs.

In a sense, the reason that split did not take place goes exactly to the heart of what the shadow Minister was saying, which is our determination to engage widely, consult local authorities and the local NHS, and come up with a set of rigorously tested proposals. This was—for want of a better way of putting it—a late addition to the work being done earlier this year, because it was already coterminous and the commission was to look at things that were non-coterminous. However, in the light of representations made by my hon. Friend the Member for Eddisbury and others, the Secretary of State was clear that it should be reviewed.

Two years was deemed an appropriate time in which to do that review, to allow that consultation with Members and others, and so that it did not straddle—subject to the passage of this legislation—the establishment of ICSs just at the time they were coming into being, and we could do that preparatory work properly. I can give my hon. Friend the Member for Eddisbury the assurance that this is a genuine and rigorous review process. When I emerge from this Committee room, perhaps I may, with Members on both sides of the Committee, discuss further what that looks like and how that might most effectively be carried out.

What that process has shown up, however, is that there is rarely a 100% consensus from all local authority partners and the local NHS on exactly what the right solution is where there is not coterminosity and we are moving towards it. That is why I am cautious about some of the language that has been used thus far, which essentially appeared to imply that we would have to have consensus, and that one part or other of the system would have, if not a veto, a right to put the brakes on changes. Were we to go down that route, I fear that, given different perspectives in different local authorities and areas, we would run the risk of paralysing any possibility of change. I think the right balance needs to be struck.

Karin Smyth: I hear what the Minister is saying, but on that basis—I think this is fundamental to all of this—why would we have local authorities or unitary authorities making any sorts of decisions? That is how local people exercise their democratic will. Bringing forward proposals in order to persuade sometimes results in a bit of stasis, but ultimately someone has to decide and break the deadlock, and the concern, as we come to some of the other amendments, is about how one does that. Local people should be able to have that in a transparent way.

Edward Argar: The approach that we have adopted thus far, which I believe is appropriate, is that we have that with local authorities and the NHS, but ultimately it is the Secretary of State who balances those in the case of these boundaries, and he is accountable to this House, so that strikes an appropriate balance. In the case of the East of England areas, certainly, we did have a very strong divergence of views as to what the right boundaries would be. It would be wrong if either local authorities or the NHS had the right to say, "No, it's this." That is where we have to have those views put forward together so that they can be considered in the round.

On the final point that the hon. Member for Bristol South made—I may have missed some points, but this is an important one that I want to put on the record—she is absolutely right to highlight the value of the work done by managers and administrators, or whatever title is used to describe them, sometimes pejoratively by some commenting on this matter. She is absolutely right about the value of their work. There is an analogy that I use all the time, with a much-hackneyed quote that Members will know: John F. Kennedy going to NASA, shaking the hand of the janitor and saying, "Thank you for putting a man on the moon." What sits behind that goes to the heart of what the hon. Lady was saying. The NHS is a team. Without effective managers, people who can engage, and people who can manage budgets and ensure financial transparency and accountability, and without planning and people who make sure that patients are called and appointments are rescheduled, those on the clinical front line, if she will allow me to put it this way, would not be as effective at doing their job. It is not an effective use of a clinician's time to ring up a patient to rearrange an appointment. Similarly, it would not be an appropriate use of the time of a highly skilled manager or administrator to be performing some other task. We have got to make sure that we have the right people in the right places, with the right skills.

The final point I would like to make again goes back to a point that the hon. Member for Bristol South made, about accountability. I think it was Amanda Pritchard, chief executive of the NHS—forgive me if it was Mark Cubbon, the chief operating officer—who highlighted, in asking who was accountable, that the ICB is an NHS body, working in partnership with the local authority, that is accountable for the funds it spends, which are voted on by Parliament. That is why it has an NHS official and there are routes of accountability up through the NHS to NHS England, and ultimately to the Secretary of State and this House. That is the structure of the NHS that has evolved over the past 70-plus years. I think that the hon. Lady sought—quite rightly—to press and challenge me on whether we think that evolution is the right approach, or whether we need to take a step back and challenge some of those assumptions. She is right to do that, but in this context, which involves the management of public money, the structures and accountabilities are correct.

I am sorry to disappoint the shadow Minister, as I fear that we will not be able to support his amendment. I hope he will not press it to a vote and that I have gone some way towards addressing the points made, particularly with regard to ICS boundaries and processes followed.

Justin Madders: We have had a fairly wide-ranging and useful debate. A number of issues have arisen that we will return to as the Committee makes progress. I am

[Justin Madders]

disappointed that the hon. Member for Eddisbury could not come on board; perhaps I should not have made my little dig about barristers this morning, otherwise he might have been more inclined to support us. I noted the sympathy he expressed and I think he articulated very well his knowledge of the geography of the area and why there are concerns locally about proper accountability in such a large area.

The irony of the whole debate, of course, is that we are discussing the Bill today, but before we have even got to the end, we know that the Cheshire and Merseyside ICS may not survive two years. Before the Bill has even become an Act, some of its constituent parts may be reorganised in future. We will see what happens on that, and I look forward to engaging with the Minister in that process.

Let us not forget that the genesis of what is before us was the STPs. How were they put together? I think local NHS leaders were sent a missive about three days before Christmas to say, "Can you give us an idea of what you think the most optimal design of your local NHS would be? By the way, we would like the response back by the end of January." As we know, the NHS is traditionally extremely busy at that time of year, and Christmas is hardly a good time to be engaging with the wider public sector or indeed the community, but that was where the genesis was, and that is where the Cheshire and Merseyside STP and now ICS came from. It would be interesting to know how many of the 42 areas have changed since that original geography back in, I think, 2017—perhaps even 2016. It was clearly then, as it still is, a creature of the NHS, not the communities it represents.

3.15 pm

The SNP spokesperson, the hon. Member for Central Ayrshire, was correct in her comments. The basis for these decisions has never been entirely clear. The Minister did set out in a written statement what had been decided, but the why was missing from that, and a lot of the frustrations that have come out today have surfaced from that. My hon. Friend the Member for Bristol South gave a real tour de force, expressing many the concerns we have about the Bill. I agree that we do not want to have an entire debate about geography all the time, and we should not: if we had got this right in the first place, we would not need to have the debate at all. My hon. Friend was right in saying that these bodies have to be perceived as relevant by the communities they serve.

Dr Whitford: Does the shadow Minister think that the fact we have heard today that Cheshire and Merseyside could be reviewed as quickly as in two years' time might undermine some of the commitment on the ground? If people feel that it will all change again in two years, the engagement may be weakened.

Justin Madders: I thank the SNP spokesperson for her intervention. That is undoubtedly a risk. It is possible we end up with two or three areas out of that review. I hate to think it would get any bigger.

In terms of what people think is their relevant community, Merseyside has a metro Mayor now with very clearly defined geography, and Cheshire is a different area. As my hon. Friend the Member for Bristol South said, people do not take to the streets with banners saying, "Save our CCG!" I suspect the majority of people do not even know what a CCG is or the area that it is meant to cover. I suspect even fewer people know what an ICS is and what area it covers. That will definitely have to change if we are to have a truly integrated health and social care system.

The point made by my hon. Friend the Member for Bristol South about the defensive culture at times, alluded to by Sir Robert Francis, is a valid one. We may touch on that in the HSSIB elements of the Bill later on. She was asking the right questions—how can the board be challenged, and who is it accountable to? Those are points we will have to come back to, because there is, to our mind, a clear democratic deficit in the way these bodies have been structured.

Finally, the Minister referred to his guiding principle of coterminosity except in exceptional circumstances. Cheshire and Merseyside is coterminous, it is just coterminous for more than one local authority—and some pretty big ones at that—so I do not necessarily think that coterminosity is the answer.

The Minister referred to proposed new sections 14Z25 and 26 in regard to the duties to consult with members of the ICB. Some of the people named in amendment 49 might not actually be on the ICB, because they are not included in the legislation at the moment. We will come to our amendment on that in due course, and we might be able to change that. In proposed new sections 14Z26, CCGs must

"consult any persons they consider it appropriate to consult".

That could be everyone and no one. I do not intend to press this to a vote, but I hope the Minister has taken on board several points that will lead to an improved process in the future. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Edward Argar: I beg to move amendment 10, in clause 13, page 9, line 44, leave out from beginning to end of line 12 on page 10 and insert—

"(1) NHS England may, in connection with the abolition of a clinical commissioning group under section 14Z27, make a scheme for the transfer of the group's property, rights or liabilities to NHS England or an integrated care board.

(2) NHS England may, in connection with the establishment of an integrated care board, make a scheme for the transfer of property, rights or liabilities to the board from—

(a) NHS England,

(b) an NHS trust established under section 25, an NHS foundation trust, or

(c) a Special Health Authority established under section 28.

(2A) NHS England may, in connection with the variation of the constitution of an integrated care board or the abolition of an integrated care board, make a scheme for the transfer of the board's property, rights or liabilities to NHS England or an integrated care board.

(2B) The reference in subsection (2A) to the variation of the constitution of an integrated care board is to its variation by order under section 14Z25 or under provision included in its constitution by virtue of paragraph 14 of Schedule 1B."

This amendment adds a power for NHS England to transfer property, rights and liabilities (including rights and liabilities relating to a contract of employment) from certain NHS bodies to an integrated care board on its establishment: see new subsection (2). In consequence, new subsections (1), (2A) and (2B) restructure material currently in subsections (1) and (2).

The Chair: With this it will be convenient to discuss Government amendment 11.

Edward Argar: Both the amendments are technical ones. Amendment 10 amends proposed new section 14Z28 of the National Health Service Act 2006, which provides NHS England with the power to make transfer schemes to transfer property, rights and liabilities in connection with the establishment of, abolition of or change in the constitution of ICBs or the abolition of CCGs. The amendment widens the power to make transfer schemes when establishing integrated care boards, so that transfer schemes may include transfers from NHS England, English NHS trusts or foundation trusts, or English special health authorities.

We are widening the scope of those schemes to reflect further work done by NHS England, which has noted that a small number of people currently working in those bodies may need to transfer into ICBs. It is of practical importance for NHS England to be able to make transfer schemes that will ensure a smooth transition when ICBs are established, and for all the staff who may be transferring to newly established ICBs to be fully protected by such schemes.

For all but the most senior staff transferred from elsewhere in the NHS, I assure the Committee that NHS England's employment commitment to continuity of terms and conditions, even if not required by law, will apply fully. That commitment is designed to provide stability and remove uncertainty during the transition. It is also possible for NHS England to use the schemes to transfer property and liabilities currently held by those bodies to ICBs on their establishment, although again we expect that to be rare in practice.

Proposed new subsections (1), (2A) and (2B) in the amendment restructure material in proposed new subsections (1) and (2) of the clause as drafted. That simply reflects the technical legal redrafting. The amendment therefore does not change the bodies that can be covered in transfer schemes relating to the abolition of CCGs or ICBs, or the variation of the constitution of an ICB. Those bodies continue to be CCGs, ICBs and NHS England.

Amendment 11 is consequential upon amendment 10 and is also simply a technical change. They are technical, but important amendments to ensure—and to be clear—that staff rights, liabilities and properties are in the right places in the NHS when we introduce ICBs into the system, and that the right protections are in place.

Amendment 10 agreed to.

Amendment made: 11, in clause 13, page 10, line 13, after "(1)" insert "or (2A)".—*(Edward Argar.)*

This amendment is consequential on Amendment 10.

Justin Madders: I beg to move amendment 38, in clause 13, page 11, line 10, at end insert—

"*Accountability*

14Z28A Reporting: duties on integrated care boards and the Secretary of State

(1) Integrated care boards must report annually to the Secretary of State on their actions and policies and the outcomes for patients of the services they commission.

(2) The Secretary of State must prepare and publish a report each year on the actions and policies of integrated care boards and the outcomes for patients of the services they commission and must lay a copy of the report before Parliament.

(3) A Minister of the Crown must, not later than one month after the report has been laid before Parliament, make a motion in the House of Commons in relation to the report."

It is a pleasure to move the amendment in my name and that of my hon. Friends. The heading is "Accountability" and, as I am sure the Minister will have picked up by now, we think that accountability needs to be turbo-charged in the Bill. The new commissioning bodies, the ICBs, are directly accountable to NHS England and therefore on to the Secretary of State. That was explained by Amanda Pritchard when she gave evidence last week. Each year, the ICB has to prepare a report on how it has discharged its functions and specialist duties under the various headings—improvements in quality, public involvement and so on. It has to report under lots of headings. One has to wonder how it will be able to pick priorities from all that, but that is a matter for the ICB.

ICBs must also publish their plans. The NHS, in the form of NHS England, will then assess the performance of each ICB against how it discharges its functions. Presumably, that will be at least in part with reference to those plans.

The amendment, in essence, would add the accountability of the Secretary of State to what we would describe as a fairly cumbersome but necessary regime of performance management. The slant of the reporting in the amendment is less steeped in the kind of bureaucratic tick-boxing that we understand that the Secretary of State is not a fan of, and what has to be reported is outcomes to patients--perhaps, the thing that matters most.

In the recent comparative survey by the Commonwealth Fund, the NHS lost its top slot and went down to No. 4. It was close, but not close enough. Despite usually coming top, it does badly on one of the key metrics that goes into the assessment—patient outcomes. We do well on ease of access but not so well on outcomes, which is a sad reflection. The amendment makes outcomes a priority over other factors. While the ICBs may have much to say on the day-to-day running of the NHS in the area, the ultimate responsibility for the whole system lies with the Secretary of State, even though on a day-to-day basis it may be NHS England that does the real leg work of performance management. In its new integrated form, NHS England performance manages various trusts and foundation trusts. It also runs the failure regimes for them if needed.

Ways of managing providers are well developed, but most of the skills necessary to monitor whole system performance have been lost to some extent, as management capacity in commissioners has been nibbled away. That brings me to the current weakness in holding providers to account on outcomes. Payment by results was a euphemism, as the results did not matter: the process was the determining factor. Reports on outcomes, as with on patient satisfaction, are absolutely necessary. If any system is to be taken seriously, it must seek to improve. ICBs should not see this as added bureaucracy: they should see it as reporting vital elements of healthcare. I draw particular attention to the reference in proposed new subsection (1), which refers to outcomes specifically, because we do not believe that gets as much prominence as it should.

Leaving aside the desire to produce the right reports for the Secretary of State, there is also an issue about how to make ICBs more accountable to their

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communities—we will touch on that later. Giving them sight of a nice glossy annual NHS report will not be very enlightening, and it will not help communities understand what has been done on their behalf, even if they recognise the NHS as part of their community.

Dr Whitford: Is the hon. Gentleman talking about clinical outcomes? One of the issues is having national clinical standards against which every unit and every area should be able to benchmark itself. In Scotland, we have standards for 19 of the commonest cancers, which are continuously audited. I was directly involved in developing the breast cancer ones in 2000. We have data that goes back over two decades, which means we can see improvement. It is clinical outcomes that need to be the focus, and they need to be agreed nationally: it should not be for every local ICS to decide what it measures and how. Otherwise we cannot say, "We are getting rid of variability, we are saying that a patient with this disease in Newcastle will get as good treatment as they would in Liverpool or Wolverhampton."

3.30 pm

Justin Madders: The hon. Lady is right; we still have a national health service and we should have national standards, and they should be tagged to clinical outcomes. Of course, it would be down to the individual ICBs to deliver against those outcomes, but it is right that those performance measures should be comparable across different areas.

A robust system of reporting is easier to understand and is probably the most important thing from a patient's perspective. It is so important that it should land on the Secretary of State's desk. We will talk later about how ICBs can be more accountable to their communities, but this is very much about how ICBs can be accountable to this place. I hope the Minister will accept the amendment.

Karin Smyth: I rise to support the amendment, particularly in relation to outcomes. The Government do not accept having reducing health inequalities as an aim. In my round-up of 20 years of CCGs and all the rest of it, the driver over the past 15 years has been to put primary care at the centre of those organisations, recognising that 90% of patient contacts are within primary and community services.

We heard from representatives of GPs last week, and I have spoken to my local medical committee as well. They are very fearful—we can dispute whether the evidence exists for whether clinical outcomes are better as a result of these organisations' being supposedly primary care-focused rather than dominated by the acute trusts, and whether that actually worked, but as a policy intent the Government are very firmly moving away from that position—and wondering what their real outcomes would be.

Were the Government to move along the lines suggested by my hon. Friend the Member for Ellesmere Port and Neston, a regular review of and look at outcomes in our local areas would perhaps help with that particular problem and highlight the driver that we need from community and primary care, as well as just looking at the financial dominance of the large acute trusts.

Edward Argar: It is a pleasure to rise to respond. The shadow Minister, the hon. Member for Ellesmere Port and Neston, is now having to do a lot of bobbing up and down with his amendments, and I am grateful to him for tabling this one. I fear he will not be entirely surprised that we cannot accept it, but I will try to explain to him at least why, and why I urge him not to push it to a vote, although obviously he will be the judge of that.

The amendment, as the shadow Minister has set out, would place new requirements on integrated care boards to report annually directly to the Secretary of State on their actions, and a duty on the Secretary of State to prepare and publish an annual report for Parliament specifically on the actions of the ICBs. It would also require a Minister of the Crown to propose a motion in the House of Commons in relation to the report no later than one month following its being laid in Parliament.

We entirely agree with the shadow Minister that there should be strong lines of democratic accountability from ICBs to Parliament. I hope I can give him at least some reassurance that the Bill already provides for much of the transparency and accountability that he is understandably seeking. The provisions in the Bill will create clear lines of accountability for ICBs to NHS England; they will be accountable through NHS England to national Government and ultimately, therefore, to both Houses of Parliament.

Proposed new section 14Z26 of the National Health Service Act 2006 already places a duty on ICBs to prepare an annual report explaining how the ICB has discharged its duties, particularly in relation to its activities to improve the quality of services, reduce health inequalities and have regard to the effect of its decisions on, and its involvement with, the public.

The report must also explain how the ICB has exercised its functions in accordance with its proposed forward plan and capital resource plan, as well as the steps it has taken to implement any joint health and wellbeing strategy. NHS England will also have the ability to give directions to ICBs concerning the form and content of the annual report, meaning that it could stipulate further reporting requirements for ICBs as necessary where information might be lacking. The report must be provided to NHS England and must be published

I hope the Committee will agree that that is already a comprehensive reporting requirement. Further, under proposed new section 14Z57, NHS England is also required to undertake annual performance assessments to review how each individual ICB has discharged its functions, including how it has delivered on its statutory duties. The Secretary of State will have the power to issue statutory guidance concerning performance assessments, meaning that national Government will be able to influence the methods and requirements of assessment if necessary. Again, NHS England must publish the results of each performance assessment, meaning that the public will have open access to information concerning the performance of their ICBs.

I hope the Committee will agree that the Bill therefore already provides much of the transparency and accountability that the hon. Member for Ellesmere Port and Neston is asking for, and that further duplicative reporting requirements would risk creating new and unnecessary bureaucracy. In respect of the ability of the House to scrutinise, he knows, and Opposition Members know, that they have many opportunities to table debates

on a wide array of subjects. He and his colleagues have held me and other Ministers to account, not only in these Committee Rooms but on the Floor of the House in recent months, on a whole array of subjects. With the information I have set out that will already be published, for not only the House but the wider public to read, absorb and consider, there is scope for the hon. Gentleman or any other hon. Member to table a debate in which such reports can be considered if they so wish. I believe that that provides for sufficient transparency and accountability, and I encourage the shadow Minister not to press the amendment.

Justin Madders: I understand what the Minister is saying. We still say there is not enough emphasis on outcomes and accountability to Parliament, but, as he has pointed out, there are other avenues that we can use to pursue those matters. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Question proposed, That the clause stand part of the Bill.

Edward Argar: The clause, as we have touched on in the various discussions on amendments already, inserts new chapter A3 into the NHS Act 2006, which contains a number of duties and functions in relation to the new integrated care boards. A new duty is conferred on NHS England to ensure that ICBs cover England and details the required process for establishing the ICBs.

The clause also makes provision for abolishing clinical commissioning groups, transferring staff, property and liabilities to ICBs, requiring the constitutions of ICBs to be published and requiring ICBs to make arrangements for managing conflict of interest effectively. The clause is essential for delivering on one of the core objectives of the Bill—creating statutory ICBs as a means to take an ambitious, collaborative approach to planning and delivering integrated health and care services in England. The clause will establish a smooth transition from CCGs to ICBs, providing clarity and consistency for patients as we move to these new arrangements, as well as creating continuity of employment for NHS staff.

Karin Smyth: Will the Minister give way?

Edward Argar: Yes, of course. I know the hon. Lady has a great interest in this.

Karin Smyth: I hope the Minister will address my earlier comments about the policy direction of primary and community care being front and centre in the last 15-odd years. This is a very different beast. I think that has perhaps not come out in the debate. These are very different bodies, and I wonder how he will make sure that the majority of patient contacts and the majority of the work that is done in the health service is not lost in the new organisations.

Edward Argar: I hope that I can reassure the hon. Lady. Although these organisations move beyond the CCG model to be much more collaborative, with more partnership working with local authorities and others, and the genesis of the new model is to bring those two parts together, there is no intent for, and I do not believe the practical consequence of this would be, a diminution in the voice of and the need to pay heed to primary care. She is absolutely right. For the vast majority of our constituents, the front door to the NHS is primary care services. The majority of their appointments, their consultations and their engagement is with primary care services. That voice is hugely important. I see that continuing to be front and centre.

The Bill brings together a range of other NHS system providers and the local authority. We may come back to the point when we discuss further amendments. I emphasise what we heard in the evidence sessions, which is that the membership requirements are de minimis. There can be increased numbers of voices for primary care on these boards, as Dame Gill Morgan mentioned in the way she is managing Gloucestershire. That may not fully satisfy the hon. Lady, but I hope I can reassure her that I am in the same place as her in recognising the importance of primary care and that the expertise that has grown up in understanding local communities is vital in framing a system that works effectively.

In requiring ICBs to maintain and publish registers of the interests of their members and employees—I expect we will return to this point in the future, in a different guise—the clause is an essential part of guaranteeing the integrity of each ICB's decision-making processes. It will ensure that any potential conflicts of interest are declared promptly by individuals and managed effectively. As a result, the public will be able to trust that decisions are made in a fair, transparent manner, in the best interest of the ICB's local population. I commend the clause to the Committee.

Question put and agreed to.

Clause 13, as amended, accordingly ordered to stand part of the Bill.

Schedule 2

Integrated care boards: constitution etc

Justin Madders: I beg to move amendment 48, in schedule 2, page 119, line 18, at end insert—

> "(c) the process by which any proposed changes to the policies of the clinical commissioning groups within the area for which the integrated care board is established will be consulted upon and agreed."

This amendment would require ICBs to be clear about how they would make changes in clinical policies and established models of care that have already been established and are applicable to patients in the area for which the integrated care board takes responsibility.

We are certainly getting a good workout this afternoon, Ms Elliott—hopefully the Minister will now be able to catch his breath.

As the hon. Member for Eddisbury suggested earlier, we have seen a rapid reduction in the number of CCGs in Cheshire and Merseyside—there are now nine, but there were more than that not so long ago—and it is one of the biggest ICSs, if not the biggest, in the country. I am not going to take the Committee through the angst on that again, but even with sensible coterminous boundaries, quite a lot of ICSs will have more than one progenitor CCG.

Under the old regime, every CCG had its own plans, policies, care pathways and models of care. For example, many had different rules about gluten-free products

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being available on prescription, and most Members will be acutely aware of the manifest unfairness of the postcode lottery for IVF treatment. The number of cycles people were entitled to and how old they had to be to access treatment all depended very much on where in the country they lived. It is tempting to say that, rather than having all that variation, we should just level up—the Government's catchphrase of the day—but that of course will not always be possible, and there will be variations in CCG policy that we cannot easily equate into one optimum outcome or standard, so how do we go about moving the many into the one?

The amendment would add a requirement that, in drawing up the initial constitution CCGs, which of course should be aware of the issues, make a start on place-based approaches, but there is an important job to do on harmonisation at the outset, and that is important for patients and the public. It will be contentious. We can all imagine the outrage if something that is offered in one CCG but not another is then removed from everyone in the process of forming an ICB. These are possible changes that we will see over the next 12 to 18 months, and they will be a real test of how responsive and engaged ICBs are in their local communities. We may indeed see people holding banners with ICBs on them if things are not handled well.

In the amendment, we say that the process of harmonisation or variation should be arrived at only after proper consultation. That fits in with the duty, which we have talked about already, on harmonisation, public involvement and consultation. It also highlights a gap in the specification for the job of producing the initial constitution for each ICB, which is given to the relevant CCG. As I have pointed out, it is very much up to them to decide who they consider it appropriate to consult. We want a much stronger and clearer commitment to consultation on changes that might affect patient care on the face of the Bill.

3.45 pm

Edward Argar: As ever, I am grateful to the shadow Minister for tabling the amendment in order to air this issue in Committee. I fear that I may have to disappoint him once again; it seems I am getting into a habit, although perhaps at some point I will suddenly surprise him.

We agree that it is right that there is appropriate consultation when making decisions about commissioning policies and care. The shadow Minister set out very clearly, as he always does, some of the reasons for that. I hope that I can give him some reassurance that the Bill already provides for much of what he is seeking in terms of outcomes. In clause 19, new section 14Z44 of the National Health Service Act 2006 already places a duty on integrated care boards to involve and consult the public in respect of the planning of commissioning arrangements, including on any planned changes. That would include, for example, plans by an ICB to change the range of health services available to the public or the manner in which they are delivered. This will ensure that the voices of residents, patients and those who access care and support, as well as their carers and representatives, are properly embedded in ICB decision making.

Schedule 2, which concerns the constitutions of integrated care boards, states that ICB constitutions must specify how the ICB plans to exercise its functions, including the duty to involve and consult the public. ICB constitutions must, moreover, specify the arrangements that the ICB will make to ensure transparency in that decision making. NHS England will ensure that they are appropriate and include the relevant provisions.

Under clause 13, and new section 14Z25 of the National Health Service Act 2006, NHS England will need to approve the constitution and make an establishment order for the ICB. In that respect, new section 14Z26 goes on to make it clear that NHS England can reject a proposed constitution if it is inappropriate. I hope that that offers some reassurance to the shadow Minister, and helps underline our commitment to ICBs being as transparent and as involving of patients and the public as possible. I encourage him not to press his amendment.

Justin Madders: In light of what the Minister has said, we will not press the amendment to a vote. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

The Chair: Unless anyone wishes to move amendment 1, we now come to amendment 31.

Justin Madders: I beg to move amendment 31, in page 119, line 28, leave out from "for" to end of line 29 and insert

"an initial chair to be appointed by NHS England, with the approval of the Secretary of State, for a period of no more than 2 years and for subsequent chairs to be elected by the voters in the area for which the integrated care board is established in accordance with regulations made by the Secretary of State for that purpose."

This amendment would require the first Chair of each Integrated Care Board to be appointed by NHS England, with the approval of the Secretary of State for a period of no more than 2 years and for subsequent chairs to be chosen through local election.

The Chair: With this it will be convenient to discuss the following:

Amendment 50, in page 119, line 29, leave out

", with the approval of the Secretary of State".

Amendment 51, in page 119, line 29, at end insert—

"4A The constitution must provide for all members of the integrated care board to be consulted, and for any views expressed to be taken into account, before a chair is appointed."

Amendment 52, in page 120, line 2, at end insert—

'(1A) The constitution must provide for all members of the integrated care board and of the integrated care partnership to be consulted, and for any views expressed to be taken into account, before a chief executive is appointed."

This amendment would ensure the involvement of the integrated care board and the integrated care partnership in the appointment of the ICB chief executive.

Justin Madders: Amendment 31 is about the ICB having an elected chair. Amendment 50 relates to the Secretary of State's approval to remove the chair from the ICB, amendment 51 relates to consultation on an ICB chair's appointment and amendment 52 relates to ICB and ICP members and consultation on the ICB chief executive's appointment. I hope there were not too

many "ICB"s and "ICP"s in that statement, but I will now set out some detail on the intention behind each of the amendments.

I would like to make some general points about integrated care boards. I would also like to put some specific amendments to a vote—unless, of course, the Minister does surprise me, and concedes on some of these points. Many things have been said about ICSs, ICBs and ICPs that do not appear in the Bill. In discussing this matter, some care has to be taken in distinguishing between what is actually in the Bill as it stands and what is not. In particular, the NHS document on the ICS design framework came out in July. Is anything in that document to be regarded as interpretation of the Bill? Perhaps more pertinently, is anything in the design framework ruled out by the Bill or inconsistent with it? There is a huge contradiction in all this. Many actions have already been taken, such as fixing boundaries and appointing chairs, that presume that this Committee does not have a say—that this Committee is not going to change anything. That is almost contempt of Parliament, but we are where we are. No doubt the Minister will be able to justify why he feels it necessary to instruct the NHS to get on with these things before legislation has been passed. To be fair to him, that is what they have been doing for the past five years as they have been trying to avoid Lansley, but we are in a different world now.

For us, the most significant issues are ICB composition, ICB constitutions generally, and the vexed issue of what people on an ICB actually take responsibility for. In each of those areas, we have tabled specific amendments. As we know, ICBs are the latest in a long line of commissioning models: we have had GPs, PCGs, PCTs, larger PCTs, cluster PCTs, CCGs, merged CCGs, and now ICBs. Just maybe, if we do not get this right first time—if we have to keep reinventing the wheel—the problem here is that it is always the NHS making decisions about itself. Various retrospectives have shown that CCGs and PCTs have had virtually no impact on the design of services, or in terms of innovation or better allocation of resources based on need, and it is certainly difficult to show that they have had much impact on outputs. It is worth pointing out that in some cases, these ICBs will be allocating billions of pounds of public money—in theory, at least—so when we are talking about a multi-billion-pound venture, it has to be free of vested interests. It has to be open and transparent in a way that, I am afraid to say, has not been a hallmark of the Department in recent years.

We know that many of the NHS witnesses said in their evidence that they did not want more prescription. As we have already touched on, we are probably going to have some debate about where on the spectrum we land in terms of prescription, with one end being a totally prescriptive environment and the other being a totally permissive one. As it stands, the Bill is too close to the permissive end, in this area at least; as I have already said, we do get some prescription when it suits the Department in other areas. We consider that prescription is not an imposition: it is a vital safeguard to make sure that things are done correctly, and that there is proper accountability of roles and positions. Legislating for the removal of conflicts of interest to ensure that these bodies are more representative and accountable is not a frivolous or minor matter. These are not optional matters: they are fundamental in a democratic society. We should take this opportunity to widen public and patient involvement and end what is increasingly looking like a much more internal model than perhaps was envisaged when the White Paper came out—a pattern, I have to say, that is possibly being set from the top.

In our view, each ICB should have an elected chair so we are going to push amendment 31 to a vote, because we believe it is a really important principle that we should be exploring further. There are two justifications for that, the first of which is negative: we simply do not trust those who make these appointments. We have seen far too many family members and friends appointed within the wider NHS who, it would be fair to say, have not come with CVs that obviously lend themselves to being part of the NHS family. In fact, the NHS has already announced who the chairs will be for two thirds of these ICSs, showing a complete disregard for the work of this Committee, particularly when it was decided that councillors did not even need to apply. There are a number of former councillors on this Committee, not least myself, the shadow Minister, and the Minister himself. Perhaps we might not be the best people to judge who could go on those bodies as chairs, but I certainly think that councillors have a legitimate claim to be suitable people in a number of circumstances. We need to take control of this; we need to have a democratic system.

The positive argument for electing someone is that it signifies that there is some accountability. It also speaks to a trend that we want to see continue moving forward, improving genuine representation of the public and of patients. We have elected police and crime commissioners, and we increasingly see Mayors and other elected figureheads having growing powers over services in defined geographies. We have already touched on how ICSs may not mean much to people in the street, but if there is someone at the top who has been elected by the people of an area, that gives everyone a sense of ownership and identity—there is a tangible body there that they have some stake in.

Let us take the example of Cheshire again, as it is the one I am familiar with. The annual budget for the police authority is in the region of £200 million. We of course do not have sight of the equivalent for the ICS at the moment, but let us say it will be significantly more. Cheshire CCG's budget is about six times that at the moment, and we have to throw in the whole of Merseyside on top. To my mind, we will have a rather unsatisfactory situation where someone is directly elected to represent our interests in police and crime, but no equivalent in health, where billions and billions more is spent.

We recognise that this is a departure from what has been worked on in the NHS to date, which is why the amendment would allow for a period of two years from the initial ICB appointment to enable the Government and probably the Minister to work through the detail of how elections would work, and the precise role and powers of a democratically elected chair.

As a country, we are being told constantly that we are taking back control. That should be put into practice. Local communities should be given a real say in who runs their health services. Throughout the evidence sessions, it was far from clear with which individual the buck stops.

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Amendments 50, 51 and 52 reflect our concerns about the frankly arrogant way that the membership of ICBs has been formed to date. If we do not get our wish for a directly elected chair, we still think there is a clear need for more local accountability for the appointment and removal of ICB chairs. As the Bill stands, there is a danger that the chairs are answerable only to the Secretary of State—not to the partnership, not to the community and not to the patients.

Why does the Secretary of State need to approve the chair? Is the chair there to represent the Secretary of State or to represent the ICB? As we have already covered, there is a less than glorious record on appointments by the Secretary of State. Let us take him out of the equation and ensure, as amendment 51 would do, that members of the board are consulted and their views taken into account before any chairs are appointed. After all, we would not want them to be appointed and then not have the confidence of the other board members. One of the questions that is hanging in the air is what would happen in the situation where the chair does not have the confidence of the board. There does not seem to be any clear mechanism for dealing with that situation, which we hope would not be a regular occurrence.

We could have the absurd situation where all those who work with the chair on a daily basis simply did not think that the chair was leading the organisation as they should, but because the chair retained the confidence of the Secretary of State—someone who might meet the chair once a year, if they were lucky—they remain in post. I think we can all see that that would be a very unsatisfactory situation. What does the Minister say should happen in that scenario? What would happen if members of an ICB or ICP clearly object to the appointment of a chief executive? If the Minister does not have an answer to those questions, perhaps he could support our amendments, although I may be tempting fate in even suggesting that.

Will the Minister at least set out what role his Department will have in such situations? What does he define as failure for an ICS? In what circumstances would NHS England terminate the appointment of a chief executive? How will removing the chief executive lead to improvements if, for example, the reason for "failure" is systemic issues around workforce and funding, which we will be coming on to later on? Let us make sure that the system works properly from the outset and that the leaders in it have the confidence of all those who work within it.

4 pm

Karin Smyth: I will speak mainly to amendments 31 and 50. The case for an elected chair of an ICB is very strong. As my hon. Friend said, if we accept the need for an elected police and fire commissioner, why not for health? The amounts of money we are talking about and the influence on people's daily life dwarf those even of my local council. That is what people on the boards will be responsible for. Social care is still provided through a democratically accountable local authority, so why not healthcare?

We are moving towards the NHS budget overall accounting for up to 40% of general Government spend—that is what we are looking at for the next few years. It seems to go against the grain of everything else—elected Mayors, devolution and so on—for Conservative Members to allow that quantity of Government funding from the taxpayer to be out in communities without any kind of more local democratic control. There would also be a lot more confidence that the days of crony contracts favouring friends, families and donors had been well and truly left behind were there independent heads of the ICBs. I do not know if the Secretary of State has as many close friends as the last one, but letting him make the appointments is not something that Conservative Members will want to defend.

We should therefore be electing a local health commissioner. The amendment reasonably allows a two-year period for the organisations to get established—they have enough to do at the moment—but it would then start to take away some of the problems that the Government will get into with their proposals for the integrated care board chairs. On the make-up of the boards, too, the Bill is a good opportunity, should they wish to take it, for the Government to move away from the terrible scenarios of the past few years in particular. That argument was made cogently this morning by the Minister himself, in terms of NHS England having non-executive directors, people of independence and so on as part of its board, and it can well and truly be made about these new local bodies.

We do not need to go back to the 1990s, when trusts were first invented. Friends and families were put on to those bodies, which were stuffed with worthies, with business people favoured over local people with strong links to the community. Surely we can learn from the past 20-odd years and from the past couple of years in particular. Place is central to what the Government are trying to achieve and is the general policy direction of the Minister's Department and many others, so it has to mean something and it has to be accountable.

We will come later to some of my amendments on a good governance commission, for which I hope to gain Government support; on having fit and proper tests for people to be scrutinised as suitable to come on to the boards; and, without wanting to throw back to the past, on bringing people in from the community to make the ICBs reflect their local community. In all seriousness, in our sad political situation, most ICBs will be headed up not by people are particularly sympathetic to Labour, so this is not a partisan point. It is, as the Minister started to say about NHS England itself this morning, about having people with the right qualifications—some clinical, some not. Let us have some clear criteria for how we want the boards to be governed and the sorts of people we want on them.

As I said earlier, the Government have got themselves into a real mess with accountability and with how much work the Secretary of State is doing, given how much is put on his desk—this sort of circular NHS accountability thing—so the amendments are trying to offer the Government a way through that follows their general policy direction. That was raised by NHS Providers in its written evidence

> "to make crystal clear the relationship between trusts and ICBs, and how the statutory accountabilities of trusts, foundation trusts and ICBs align. There also needs to be clarity within the legislation on how the roles and responsibilities of the current NHS England and NHS Improvement…regions, ICBs, ICPs, trusts, foundation trusts, health and wellbeing boards…places, provider collaboratives, neighbourhoods and primary care networks…will all fit together."

We would all like to understand how that works, even those of us who follow such things.

I am not suggesting that an all-powerful elected chair will get that, but at least that skilled person bringing together the multiplicity of organisations, groups and people for the local community would be a figurehead who needs to understand and grapple with the issues. The chairs would need to be trusted and highly skilled. In that way, there can be further accountability back up the national system, either through NHS England or the Minister. Let us take all that away from the Secretary of State's desk—he is going to be a terribly busy man over the next few years. Let us help him out.

The Government should support this and similar amendments to try to bring local accountability much more to the fore. That, in turn, would allow local people, who are expected to spend huge quantities of their taxes on health—increasingly so over the next few years—to be very clear about what the money funds, what they get for their money and how they can hold people accountable.

Edward Argar: The shadow Minister, the hon. Member for Ellesmere Port and Neston, said that his amendments would give me two years to work through this, if necessary. I am grateful for his confidence in my longevity in this post—only time will tell.

I am grateful for the opportunity to address amendments 31, 50, 51 and 52, which were tabled by the shadow Minister. I fear that I may not surprise him on this set of amendments. Under the Bill as drafted, the chair of the integrated care board will be appointed by NHS England, as he and other Members have highlighted. It is therefore rather disingenuous to suggest that friends and cronies will be appointed. This is an NHS England appointment, with approval from the Secretary of State. I am not quite sure what is being suggested about those at NHS England, but I suspect it is rather unfair.

The chair will be appointed by NHS England, with approval from the Secretary of State. That reflects the fact that the ICB is accountable to NHS England and, through it, to the Secretary of State and, ultimately, this House. That goes to the heart of the comments made by the hon. Member for Bristol South on the balance to be struck between having local flexibility and accountability, and recognising that this is a national health service and the way in which it has evolved. The accountability mechanisms are also national to reflect that.

In answer to the hon. Lady's questioning, the chief executive of the NHS, Amanda Pritchard, said very clearly of the ICBs:

> "In the proposed future structure, they would be accountable to a combined NHS England and NHS Improvement structure. At the moment, we operate that through seven regions, and then through to the national NHSEI executive. We are, in turn, accountable to Parliament."—[*Official Report, Health and Care Public Bill Committee,* 7 September 2021; c. 20, Q21.]

Amanda Pritchard was very clear that it is the integrated care board that carries that national statutory responsibility on behalf of the NHS, hence why we have structured the accountability requirements as we have.

That chain of accountability has been at the heart of the NHS since its inception. There is a difference, which I know all Members recognise, between the DNA—for want of a better way of putting it—of social care provision, which has evolved through the link to local authorities, and the NHS, which has a more vertical, national structure. That goes to the heart of the different DNA of those two complementary—vitally complementary—parts of the system. We have to remember that history.

That is reflected in the clear belief, which is shared across both sides of the House, that in various ways the Secretary of State is ultimately accountable to this House and, through that, to the public for the performance of the NHS. It is therefore only right that once NHS England has made the appointment, the Secretary of State, who is ultimately accountable, should give final approval for the appointment of the chair. It is an important role in the ICB, as I am sure all Members would agree, and it is right and proper that the Secretary of State ensures that the appointment is appropriate. That is why, I fear, we cannot accept amendment 50, which would remove that mechanism.

At this point, it might be helpful to address the shadow Minister's point about councillors. We need to draw a distinction between their role on ICPs and on ICBs. ICBs are the NHS accountable body for the spending of public money. As is already the case, the NHS is clear that it does not approve of dual accountability, so when someone is directly accountable for the spending of NHS money, they are required to have that as their role and to not have multiple roles. That applies to the chair and the chief exec, as is consistent with current practice. I discussed that at some length with the chief executive of the NHS when she was chief operating officer. Quite rightly, given my background and the shadow Minister's, I sought her guidance and that is the conclusion we reached.

Amendment 31 suggests that the chair of the ICB should be appointed via local elections. That brings in a new element to the accountability relationship, which, again, could give rise to the perception of conflicting accountability routes, given that the genesis of how the NHS is currently structured has been as a national health service. The amendment risks introducing a degree of tension into that relationship. Given the importance, as the hon. Member for Bristol South rightly said, of having the right, highly skilled and able people in all these roles, it is appropriate that the mechanism we propose seeks to balance local knowledge and national accountability.

The shadow Minister or perhaps the hon. Member for Bristol South—forgive me if it was—asked what happens if there is discord within an ICB or challenges to the authority, capacity or capability of an individual chair. Essentially, we come down to the constitution of the ICB. Paragraph 8 of schedule 2 sets out how that would work, and NHS England will be producing guidance. Ultimately, NHS England will have the power to remove a chair should issues arise that necessitate that, but there will be further guidance on how that would work and what thresholds there might be.

The hon. Member for Ellesmere Port and Neston raised an important point: what is the mechanism in the hopefully unlikely event that that should occur? Chairs are subject to normal recruitment processes, and NHS England's approach to appointments has been to work with the existing ICSs, including both NHS providers and local authorities, to ensure that the chairs appointed are high quality, credible and have the confidence of their local systems. Similarly, to ensure democratic involvement, ICBs have strong duties in relation to public and patient involvement, and local authorities must appoint, by right, a representative to the ICB.

[Edward Argar]

Before I turn to amendments 51 and 52, the hon. Gentleman raised some challenge about the design document, its status and whether it appeared to prejudge the House's deliberations. I want to reassure him: the key word in terms of that document is that it is in "draft" form—it is not formalised, and it is not the final document, because he is right. However, it does allows the non-statutory ICSs to be given a degree of guidance to continue their evolution, rather than all work stopping while we deliberate. Should the House pass the legislation that means ICSs become statutory, that document would have greater force. However, we are not seeking to pre-empt or pre-judge the will of the House. In fact, even with that caveat, the hon. Gentleman will be aware that we did not publish the document in draft until after Second Reading. That recognised again that we wanted the House to have a say on the principles before we even published documents in draft form and that we are cognisant of the need to show respect to the House's democratic processes.

Amendment 51 would mandate that NHS England consult with the board before appointing a chair, and amendment 52 would require the chair to consult with both the board and the integrated care partnership before appointing a chief executive. We fully accept the importance of both the chair and the chief executive having credibility among system leaders and the population they serve. That is why NHS England is working closely with local authorities, NHS bodies and others in the appointment process.

The Bill, at its heart—again, we will come to the question of balance—aims to strip out needless bureaucracy by removing processes that we believe add little in terms of ensuring high-quality or safe care and that could get in the way of collaborative, smooth decision making. The amendment to formally require consultation on the appointment of the chief executive would create an unnecessary formal requirement, as well as potentially duplicative work, given that we would anticipate this happening informally anyway, and having due regard to that.

We believe that the approach taken in the Bill ensures both patients and the public have a strong voice on ICBs while also ensuring that the accountability arrangements set out by the chief executive in her oral evidence are maintained upwards as well, to the House and the Secretary of State. I therefore ask the shadow Minister to consider not pressing all his amendments to a vote.

4.15 pm

Justin Madders: We have had an interesting debate, and I think we have seen the stark differences in approach. Certainly, Labour colleagues see the proposal as an obvious thing to do. As my hon. Friend the Member for Bristol South said, the NHS will account for about 40% of all Government expenditure, so it seems obvious to want some kind of accountability for how it is spent on a local basis. The Government have decided to split the NHS up into 42 areas, so this seems an obvious thing to do, but I appreciate that the Minister comes at this from a completely different perspective. It might say something about the culture of the NHS and perhaps the insularity in how it does things.

When the Minister talked about not being here in two years' time, he was of course referring to the inevitable promotion that he is due. Perhaps he will be promoted to the Home Office, in which case he will be dealing with police and crime commissioners. Perhaps at that point he will be persuaded of the benefit of having locally elected individuals responsible for services. Of course, we did not have police and crime commissioners until the coalition Government decided to import them from America, and although there is certainly a degree of scepticism about them, if they are a good thing for policing, I see no reason why the NHS should not embark on a similar route.

I envisage some tension between those who sit on an ICB who have some democratic mandate, perhaps from the local authority, and those who do not. Would they be seen to have greater legitimacy? Would their vote carry more weight than other ICB members, because it could be argued that, in the eyes of the public, it would? I think that we are storing up problems for further down the line. If we are to see this levelling up—this renaissance of place—in towns and cities up and down the country, we will need a focal point in all our public services, and none is more important than health and social care.

The Minister suggested that those involved in NHS England might not be appointing people in the most straightforward manner. I was certainly not implying that in my comments, because, as he conceded—this makes me wonder why he is not prepared to support amendment 50—all these appointments still require the approval of the Secretary of State. That is the bottom line. If that is not necessary and the Minister has full confidence in NHS England to make the right appointments, we do not need the Secretary of State's approval, so the Minister can support amendment 50.

Turning back to amendment 31, which I will press to a vote, we think that a focal point of local accountability is vital. When something goes wrong, when decisions are made that people are unhappy about, or when people just want answers, they need a figurehead that they can go to. They need someone they can hold to account at the ballot box, as is our democratic tradition in this country. I do not think that they will get that with ICBs. If the Minister does not support the amendment, I really think this will be a missed opportunity, and I hope that in future years he will think again on this point.

Question put, That the amendment be made.

The Committee divided: Ayes 4, Noes 9.

Division No. 3]

AYES

Madders, Justin	Owen, Sarah
Norris, Alex	Smyth, Karin

NOES

Argar, Edward	Robinson, Mary
Crosbie, Virginia	Skidmore, rh Chris
Davies, Gareth	Throup, Maggie
Davies, Dr James	Timpson, Edward
Gideon, Jo	

Question accordingly negatived.

Amendment proposed: 50, page 119, line 29, in schedule 2, leave out

", with the approval of the Secretary of State".—*(Justin Madders.)*

Question put, That the amendment be made.

The Committee divided: Ayes 4, Noes 9.

Division No. 4]

AYES

Madders, Justin	Owen, Sarah
Norris, Alex	Smyth, Karin

NOES

Argar, Edward	Robinson, Mary
Crosbie, Virginia	Skidmore, rh Chris
Davies, Gareth	Throup, Maggie
Davies, Dr James	Timpson, Edward
Gideon, Jo	

Question accordingly negatived.

Alex Norris: I beg to move amendment 32, page 120, line 26, in schedule 2, at end insert—

"(d) at least one member nominated by the mental health trust or trusts that provide mental health services within the integrated care board's area;

(e) at least one member nominated by the Directors of Public Health that serve each local authority within the integrated care board's area;

(f) at least one member nominated jointly by any NHS trust, NHS foundation trust and local authority that provides social care services within the integrated care board's area;

(g) at least one member nominated by the trade unions representing the health and social care workforce that serves the integrated care board's area;

(h) at least one member appointed to represent the voice of patients in the integrated care board's area."

This amendment would require integrated care boards to have members nominated by Directors of Public Health, mental health trusts, social care providers and trade union representatives and a member representing patients.

The amendment seeks to enhance the prescribed members of the integrated care board. We have not been able to move the Minister on the chairing, but I hope we might be able to do a bit better on the board members.

These are exceptionally important roles. The decisions that these bodies make will shape communities and lives. As we have heard, the boards will be accountable for spending hundreds of billions of pounds of public money. We are banking on their leaders taking good care of that very profound responsibility, and taking integration from an academic concept, or something that is seen in some places, to a real-world idea across the country. That is a big ask, and we need the very best people on the boards and the best range of voices.

Prior to coming to this place, I was a system leader in my local health system. I chaired my health and wellbeing board for a number of years and led my council's health and care functions. That dual responsibility is hard, because our every instinct is to think "system first"—certainly in local government, because we know that the best prize and the best step changes in the wellbeing of the community come when organisations work together. We know that, but we also butt up against the grinding realities of one-year budget cycles and diminishing financial resources, so we find ourselves in one meeting—a board meeting perhaps—where we are desperately trying to move forward the cause of integration, or the common cause of the shared vision in a community, but we know that when we get back we have to meet finance colleagues in local government, and there is a reality to that.

That duality is really hard. I always likened it—people rolled their eyes in my health and wellbeing boards, and they may roll their eyes in this Committee too—to playing for an international football team, because people come from their clubs, but they come together for a common purpose. They wear a different shirt. The reason that matters is that they do not forget who they were previously—none of that goes away—but in that moment, they are trying to work in a common cause and put aside any of the parochial or local differences they have. That worked best with a balanced and diverse set of voices and experiences around the table, and I do not think that the Bill supports the appointment and assembly of a balanced and diverse set of voices.

The more I have listened to the Minister, the more concerned I have become about that issue, because on two occasions he has characterised integrated care boards as essentially NHS fund-holding bodies that therefore sit within the NHS accountability structures. I absolutely agree that that is true, certainly in this schedule, but in that case, is this not just a bigger CCG with an integrated care partnership moored to it? What really is different here?

We have said throughout—and have been told that we are wrong, and perhaps overly cynical in saying so—that this is an NHS reorganisation Bill, not an integration Bill. I am afraid that the Prime Minister rather weakened Ministers' arguments by saying that there needs to be an integration White Paper, which I thought was an extraordinary indictment of this legislation. If this is a Bill regarding integration, who is integrating with who? There do not seem to be multiple parties; there seems to be a single party, perhaps with different elements and slightly different email addresses, but still with broadly the same accountability structures. At this point, this does not feel like integration.

In the previous sitting, the Minister described the current composition of the boards as a de minimis one, and said that there could be more members. I hope there is an expectation—he might address this when he replies—that generally, there would be more than the five people currently set out. Paragraphs 3 to 7 of schedule 2 set out the minimum of five members who will form the integrated care boards: the chair and the chief executive—there must be two of them—and then one member to represent all the NHS trusts, one person to represent primary care, and one person to represent all the local authorities in the area. The first time I read about those three ordinary members, I thought, "Those poor people." One person to represent all the trusts in an area? One to represent all the local authorities in an area? Goodness me, that is a challenge.

I understand that the Minister is not keen to be overly prescriptive beyond what is in the Bill, and that there is a desire to strike a balance between being permissive and being prescriptive—trust me, nobody gets more frustrated with people in London telling people in Nottingham what to do than I do. However, given what is in the rest of schedule 2, I think the Minister is in danger of undermining that argument.

[Alex Norris]

As we have heard, paragraph 4 says that only NHS England can choose the chair; paragraph 5 says that only NHS England can remove the chair; paragraph 14(2)(a) says that NHS England can vary the constitution of a local integrated care board; and paragraph 14(2)(b) says that NHS England can stop any other amendments to that constitution. We should not give too much succour to the idea that this part of the Bill is going to be particularly permissive, and that there is not going to be prescription in there. Of course there is, because we want local communities to shape their planning and their approaches, but we also think that there are minimums—I think we could find a level of commonality relatively easily—and we want to establish them as a backstop. Obviously, we have five here, but I think we ought to go a bit further.

As such, my amendment suggests five other members, the first of whom would be a representative of a mental health trust or similar. Again, if the Minister thinks I am wrong or that I have misunderstood this, I would be keen to hear from him, but I think it is exceptionally unlikely that the ordinary member chosen to fill the role described in paragraph 7(2)(a) on behalf of NHS trusts in a particular integrated care board footprint would not be from the biggest acute trust in that patch, or at least from one of its acute trusts. Our big hospitals are the gravitational centres of a local health system. They are totemic to a local population, they are massive financially, and they are exceptionally powerful in terms of soft power in a community. That means that there is one place and that place is gone, so once again, there is nothing for mental health.

We talk so often in this place about the need for parity of esteem between mental and physical health, but this is an opportunity to demonstrate that in practice, and we are not taking it. Beyond the fact that we ought to be putting mental and physical health on an equal footing, so many of the knotty issues that we will want local health systems to tackle will be rooted in issues relating to mental ill health, so I think there needs to be a voice at that table that can give balance to the decision making.

4.30 pm

Edward Timpson: I am grateful to the hon. Gentleman for giving way, and I understand his desire to try to push the agenda of some very important parts of our healthcare system, including mental health. Is he cognisant of the evidence that we heard from Dame Gill Morgan, who has already set up an ICS and who has perhaps done some of the testing for us on what works best? She said:

"In our case, we will have mental health and social care around the table, not because we are told to but because we could not imagine how we could do our work at a local level without having those people feeling that they are full partners and sitting around the table."—[*Official Report, Health and Care Public Bill Committee,* 9 September 2021; c. 133, Q186.]

Does the hon. Gentleman think it is important that we listen and learn from the experience to date in order to ensure that—to use the hon. Gentleman's football analogy—we do not have too many people on the pitch? The analogy falls down, because it is possible to have only 11 on a football pitch. The danger is that we end up with too many people, which is unworkable and unmanageable.

Alex Norris: I am grateful for that intervention—I am going to stop at 10. That evidence actually supports the point the I am making. When we heard that evidence, the witness said that it was automatic to them, but of course we would want someone from a mental health background and someone from a social care background. I completely agree. What I am saying is that if that is so clear and obvious, which I believe it is, why on earth would we not put it in the Bill? It was clear and obvious enough that we wanted to have someone on behalf of local authorities, and that we wanted someone on behalf of primary care. If it is clear and obvious in those cases, it is clear and obvious in these, too. That was my reasoning, and it was obviously echoed in the evidence submitted by the Royal College of Psychiatrists and the Mental Health Foundation. That is the first thing I want to say about the amendment.

The second relates to a director of public health drawn from that patch. Goodness me—as my hon. Friend the Member for Ellesmere Port and Neston said this morning, if anyone has proven themselves under fire over the last 18 months, it is our incredible DPHs. With a unique combination of knowledge, training, local insight and cross-system relationships, they have done an extraordinary job for us in pulling together our approach to the pandemic. We should be using that to pull together our approach to all sorts of big issues that we face in our local communities.

The DPHs are the human embodiment of our communities' joint strategic needs assessment. They bring that to life, and they could bring that to the table. If we want our system leaders to go beyond their organisational concerns when they go into their integrated care board meeting, who better than the person who develops the insight into system need? The DPH is exactly the right person. They also provide an invaluable director-level connection to all the departments of the local authority that have such a profound impact on the wider determinants of health—housing, leisure and planning. What a wealth of knowledge, and what connections, they would bring to the table.

Thirdly, the amendment provides for a designated social care representative. The stated aim of the Bill is to drive integration and to foster collaboration between health and care partners. I really want that to be the case, rather than this being just a reorganisation Bill. It is a 135-clause Bill, and two of the clauses are about social care, so it is not unreasonable to say that perhaps there is an imbalance. Rather like the much-hyped social care reform and funding plan that the Government are discussing downstairs at the moment, the clauses in the Bill neither reform nor, in the main part, fund social care. Again, social care is left trailing behind. It has been battered for 11 years and, as a result, we see rationed care, dreadful terms and conditions for staff, and services that are just not fit for what they were supposed do. If the Bill really is about fostering collaboration, social care ought to be explicitly represented.

I am conscious that there is a nominated local authority representative under paragraph 7(2)(c) of schedule 2, but that person will already have quite a lot on their plate. They will have to represent the broader views of

the entire local government family. Nottingham and Nottinghamshire is probably one of the simpler planning footprints in the country, but it is still 11 counties, and representing all those views at once is very difficult. It is too much—and not credible—to represent not only 11 council chief executives, but 11 directors of adult social care and children's social care, as well as all the other functions of the local authority. A social care lead, who convenes the social care leads in the given geography, would give the ICBs the specialist knowledge and insight to create and foster the environment for a true partnership between health and care.

Fourthly and penultimately, amendment 32 would replace the staff voice through recognised trade unions. As has already been mentioned, our health and social care services are well served with amazing staff. They are our experts. They are the people who feel things on the frontline and who know, when they go, "Here we go—here's a new initiative", whether it is practical and rooted in real-world experience. They have that very direct experience of population health and how it is changing over time.

The staff are the ones telling us about the fractures in the health and care system that make their jobs harder—the fractures we are supposed to be dealing with. They were the ones—boy, should we have listened to them then!—who told the Government very clearly what the impact of the 2012 reforms would be on the system and about the greater fracturing of the system. They were not listened to then, but they should have been and they should be now.

Prior to coming here, I was a union organiser. I know one thing for sure: senior management always think they can speak for the staff, but I am afraid they generally cannot. That is not a criticism; their lives at work are very different. The health and care family is better served when all aspects are covered, rather than some speaking for others. If we are going to develop really significant plans at these boards, the discussion would be incredibly enriched if the voice of the frontline was there, to sense-check things, to highlight things that are working already and the workarounds that staff develop as time goes on, and to assist on planning as well. There is an awful lot they could contribute.

Finally, and crucially, let us have a representative of the patient voice. The whole reason why any of us come to this place is that we want to give communities a voice. We think that is important. The key way we do that is to listen to people. If we do not, we do not do very well for very long.

We want our communities to have brilliant health and care services, but sometimes we make it harder for them to tell us what they want. We have tremendous mechanisms for finding out. The evidence of Sir Robert Francis from Healthwatch was particularly pertinent on not just using numbers, but the wealth of qualitative information. Let us have someone who is an expert by experience and who can draw on and bring that with them, and speak for thousands of other experts by experience. We must believe that they have as much to contribute as senior leaders. Not only would they bring insight, but it would give legitimacy to decision making, which is something that we have real concerns about, as we have said on discussion on multiple groups of amendments.

Those are the extra five members we are suggesting. If anyone listening at home is keeping score, that means five members—the chair, the chief executive, the acute lead, the primary care lead and the mental health lead—who owe their employment fundamentally to the NHS, and five—the local authority lead, the DPH, the social care representative, the staff representative and the patient representative—who do not.

If the Bill is about integrating and not about a restructure and reorganisation that involves the big acutes taking on the rest of the system, that might be quite an elegant balance. Of course, local systems could seek to augment that, which would be a matter for them, but this would be a very solid foundation, which I think enriches the board. I look forward to the Minister's response.

Dr Whitford: I, too, rise to support the amendment. This is probably one of the most important amendments so far. In the witness discussion, we came back time and again to which voices would be on the ICB and would be able to influence. I agree that, with all the talk of parity of esteem, it seems incredible that there would not be a voice representing the importance of mental health on the board. Similarly, with the talk of moving to population health and wellbeing, there is a need for directors of public health to agree policy and to feed in information about the underlying health inequalities, life expectancy and so on in the local population. Not to have a social care voice when what the Government say is that they are trying to integrate the NHS with social care seems quite bizarre.

The NHS and social care are both services delivered by people for people and having both the workforce and staff voice, and the patient voice, is therefore important. On the staff voice, the "Learning from Scotland's NHS" report from the Nuffield Trust highlights that the success of both the Scottish patient safety programme and the Scottish quality improvement standards was driven by the fact that frontline staff were involved as drivers, champions and developers from the word go. These programmes have been able to run over years, building on experience that is then shared with other sectors and specialities. It is important to get this part of the Bill right, or else priority will not be given to integration, population health or wellbeing. Of all the things that have been discussed so far in Committee, and through the witness statements, this amendment is one of the most important.

Edward Argar: This is an important amendment because it goes to the heart of the debate we have been having about permissive versus prescriptive, and where the appropriate balance is. I suspect we slightly disagree on that—perhaps a little less than one might suppose—but I am grateful to the shadow Minister, the hon. Member for Nottingham North, for bringing this amendment forward. It gives us the opportunity to start getting into that permissive versus prescriptive debate. At the outset he raised the recent announcement by the Prime Minister about integration; it will not surprise him when I say that I believe this creates the foundations of that integration, on which we can continue to build in the coming years.

In respect of the specifics of the amendment, schedule 2 sets out minimum membership of the integrated care board. That is the key element here. It will need to include members nominated by trusts, foundation trusts,

[Edward Argar]

persons who provide primary medical services in the ICB area and local authorities. As we heard in the witness sessions, this is very much de minimis—it is not what will happen; it is the baseline, above which each system can go if it wishes to reflect local needs and priorities. We have heard the quote from Dame Gill Morgan about how she is approaching it, but we have also heard from Richard Murray of the King's Fund, who said:

"You could easily criticise the degree of permissiveness; you could criticise the degree of direction in there. The question should be, 'Can anyone come up with a better one?' We have not been able to do so, so I think it is a balance well drawn."—[*Official Report, Health and Social Care Public Bill Committee,* 09 September 2021; c. 127, Q173.]

I appreciate that shadow Ministers may take a different view because they feel they have come up with a better balance. However, I highlight that evidence before I go into my answer.

Dr Whitford: Obviously, Dame Gill Morgan is quoted as saying that no one could evenly remotely think of setting up an ICS without primary care voices—and these other voices. Are all interim ICSs that have developed so far following the same model as she is? Is this totally intuitive, and therefore to be relied on, or should it actually be laid down? The voices listed in this amendment are central.

Edward Argar: The hon. Lady and I have spoken about "Learning from Scotland's NHS" before; as she will know, we are not dogmatic and are always happy to learn from Scotland's NHS—as, I am sure, it is happy to learn from England's NHS. That is to the benefit of everyone, and I am very grateful to her for inviting me on Second Reading to come and visit Scotland and see it on the ground, which I hope to do.

The reality is that the ICSs at the moment, on a non-statutory footing, are at different stages of development, different stages of evolution and reflect different approaches. One of the things we are seeking to do here is to put a non-restrictive degree of prescription around this—if that is possible—to get a degree of consistency, but not to be too prescriptive.

Dame Gill Morgan leads one of the more developed ICSs. I do not think what she is saying would be unrepresentative of the attitudes and approaches adopted by ICSs more broadly. I should say ICBs, as the hon. Member for Bristol South rightly highlighted the importance of reflecting careful use of the terminology in the evidence sessions—she caught my eye, and I have corrected myself now. I think we strike the appropriate balance here, and I suspect we will see ICBs going further in their membership, but that flexibility is able to reflect local circumstances.

Edward Timpson: I wonder whether my hon. Friend the Minister could assist the Committee with a question on the evidence given by Louise Patten from the ICS Network, who said that, on top of the five mandated board positions in the Bill,

"a further five will be in the mandated guidance from NHS England."—[*Official Report, Health and Care Public Bill Committee,* 9 September 2021; c. 134, Q186.]

Is that something that the Minister has been sighted on? If so, do we know what those positions are? I fear that the hon. Member for Nottingham North might have to start to move to a substitutes bench to get enough people around the table, based on his amendment.

4.45 pm

Edward Argar: I am pleased that I do not see any signs of the hon. Member for Nottingham North moving to the substitutes bench any time soon. However, my hon. Friend is absolutely right. I do not want to pre-empt the detail of the guidance, but, as Louise Patten said, the whole purpose of this is to provide the ability to further supplement what is on the face of the legislation with guidance that the ICBs will have regard to.

Justin Madders: Perhaps the Minister can help me. When I read the guidance, I understood that it meant that there would be at least 10 individuals on any ICB. Does the Minister think that is the correct number?

Edward Argar: The key focus for this amendment is what the legislation sets out in this clause, and that is the five positions—that is what we want to specify on the face of the legislation. I will come to the detailed guidance, but first I will go through a few of the remarks from the hon. Member for Nottingham North in support of his amendment.

At the heart of the issue is our desire for the provisions of the Bill not to be too prescriptive regarding the membership requirement, beyond that proposed statutory minimum. The guidance is a different matter from what is in the actual legislation; we want the statute to specify that de minimis. We believe that it gives the right approach and balance, having key voices and local flexibility to add voices—including those the hon. Member has proposed, but others as well—and that it reflects the evidence given by Martin Marshall, who said that the boards have to be kept to a workable size to be able to make decisions effectively. Again, that is permissive.

I come back to the point that local ICBs can appoint more members, should they wish to do so. They can go significantly beyond the legislative minimum requirements if they so choose. Therefore, we do not believe that prescribing further membership is necessary. Of course, schedule 2 states that ICBs will need to publish details of their membership in their constitutions. Under clause 13, proposed new section 14Z25 of the National Health Service Act 2006, NHS England will need to approve the constitution proposed by each ICB. Again, we come back to that approval process.

Justin Madders: Of course, the evidence from the Gloucestershire ICS was that of course those individuals—some of whom are included in our amendment—would be on the ICB. From our perspective, it is clear that all the individuals we have named are critical players in any local health system. Could the Minister set out which of those included in our list, if any, he does not think would be appropriate to sit on an ICB?

Edward Argar: I think that all add value, but equally, in some circumstances, we see different local arrangements; in some localities, some people fulfil more than one role or sit in different places.

The hon. Gentleman asked me to cover his specific point about the guidance before I conclude: the guidance will not prescribe additional roles in the same way that legislation prescribes or mandates, but it does seek to set out best practice, highlighting what would be deemed to be best practice—drawing on experiences such as Dame Gill's, I suspect. We would expect that ICBs would pay due heed to that guidance, alongside their de minimis legal and statutory obligations.

If in time, when those ICBs are up and running, it becomes clear that that approach needs strengthening and that we need to add further requirements, regulation-making powers in schedule 2 will allow the Secretary of State to do so at a later point. We believe that it is right to start at this de minimis point in the Bill. It reflects our view, which I have articulated throughout, that we must not attempt to over-legislate at this stage on the composition of ICBs, letting them evolve as effective local entities, to reflect local needs. It may not fully reassure the hon. Gentleman, but there is a mechanism whereby further changes could be made in future, although we do not believe that will be necessary.

The amendment takes a different approach, which is essentially more prescriptive and less permissive. I do not dispute the sincerity of that approach, but it comes down to a matter of where we feel the appropriate balance should be struck. I fear that, although the shadow Minister and I are quite close to one another in our region of the east midlands, we are slightly more distant in respect of the amendment, but I am grateful to him for affording the Committee the ability to debate a key point of principle in the approach to the Bill.

Alex Norris: I am grateful to the hon. Member for Central Ayrshire for her contribution and for sponsoring our amendment. She spoke about the way staff have not only improved patient safety and the quality improvement programmes, but made them stand the test of time. We are sometimes in danger—the Bill is a good example—of building things that do not stand the test of time and keep being changed, and she went through all the various situations. If we pass any test, it should be that one. The amendment is certainly one way of improving our chances on that.

I am grateful to the Minister for his comments, too. I understand the de minimis point, but I still cannot envisage a scenario in which we would not want a mental health rep on the board. I live in undoubtedly the best place in England—in Nottingham—but we still have mental health problems and need mental health leaders. If we need mental health reps, and we certainly do, I think that everybody probably does.

The Minister's response did not quite address the point about balance. The balance of the five members is four NHS and one non-NHS. The whole business maxim is no mergers, only takeovers. If the provision is really about integration and partners coming together on an equal footing to improve the population's health, everything that we have heard so far does not fit with that. What we have heard so far is about organising this round with the terms of reference that NHS England wants, and if local communities and local authorities wish to be part of that and know their role within it, that is absolutely fine. I think we should aspire to do better, so I will press the amendment to a Division.

Question put, That the amendment be made.

The Committee divided: Ayes 5, Noes 9.

Division No. 5]

AYES

Madders, Justin	Smyth, Karin
Norris, Alex	
Owen, Sarah	Whitford, Dr Philippa

NOES

Argar, Edward	Robinson, Mary
Crosbie, Virginia	Skidmore, rh Chris
Davies, Gareth	Throup, Maggie
Davies, Dr James	Timpson, Edward
Gideon, Jo	

Question accordingly negatived.

Alex Norris: I beg to move amendment 30, in schedule 2, page 120, line 26 at end insert—

"(2A) The constitution must prohibit representatives of GP practices with active Alternative Provider Medical Services contracts from becoming members."

This amendment would mean that the only GPs able to participate in integrated care boards would be those whose practices are on the standard General Medical Services (GMS) contract.

The Chair: With this it will be convenient to discuss the following:

Amendment 33, in schedule 2, page 120, line 26, at end insert—

"(2B) Representatives of private providers of healthcare services, other than general practitioners who hold a contract for the provision of primary medical services in the area, may not be appointed to integrated care boards."

This amendment prevents private providers of healthcare services from becoming members of integrated care boards.

Amendment 27, in clause 20, page 29, line 9, at end insert—

"(4) Representatives of private providers of healthcare services, other than general practitioners who hold a contract for the provision of primary medical services in the area, may not be appointed to integrated care partnerships."

This amendment prevents private providers of healthcare services from becoming members of Integrated Care Partnerships.

Alex Norris: We have not had success with chairs, and we have not had success with who should be on the board, so we move on to who should not be on the board. Let us see whether this alternative tack might prize the Minister away from not giving us his support.

The amendment would mean that representatives of GP practices with alternative provider medical services, or APMS, contracts were prohibited from participating in integrated care boards. That would mean that, under schedule 2, they could not provide that primary care representative.

Let me briefly explain the context. The vast majority of practices—nearly 70%—operate under the general medical services, or GMS, model. That is the standard contract and the most usual model of partnership whereby a CCG or NHS England contracts with a local general practice. Another quarter or so operate on personal medical services, or PMS, models. There is a little more flexibility for commissioners to tailor to local need—this is not agreed as a standard contract like the GMS at

[Alex Norris]

national level—and again the arrangement is with a local practice. However, these are not particularly en vogue; they are being phased out, I understand.

That leaves the remaining portion, which is on APMS. That is a much more flexible contracting model and very much a child of the previous decade. Here, commissioners can contract with organisations other than GPs or GP partnerships, and can contract, for example, with private companies.

APMS contracts—without that GP requirement and with shorter durations—offer the easiest way for large private companies to take over practices. Those are companies motivated by profits, rather than their patients, and their having a voice on the board would run contrary to what I am sure Members on both sides of the Committee seek to achieve. I would say it was contrary to the triple aim of the Bill.

However, this is a model on the march and one that could change general practice beyond recognition. My colleagues and I do not think it should exist, but we will make our case on that when we deal with clause 16 and amendments 28 and 29, so I shall have to keep the Committee in suspense. The amendment would mean that a representative from such an APMS partnership could not be part of the ICB and could not fill that place.

As my colleagues and I have made clear previously, we think it paramount that the Bill put patients front and centre. For many patients, using the health service begins and ends with their GP for big parts of their life. The GP is someone they have known for years, someone they can trust and someone who plays an active role in and knows their community.

The pandemic has created some access issues, but the care that people have received is still exceptional. The latest GP survey found that 89% of patients said that the healthcare professional they last saw was good at listening to them and giving them enough time, 88% said that that healthcare professional was good at treating them with concern, and 93% said they were involved as much as they wanted to be in decisions about their care and treatment. Our local GPs are really good and do the job really well. It is not much of a stretch to think that those are the sort of people that the public want speaking for them in these ICB structures. That would be very welcome.

We also know that, whether my supposition that the ICBs are going to be really big CCGs is right or not, CCGs had significant involvement from primary care clinicians and the ICBs will have less. That is definitely a point beyond contention, but there is still a reserved place on the board. However, this is a perfect opportunity for local GP leaders to fill that space, and with regard to APMS contracts, I do not think that those representatives will provide that same involvement.

I appreciate that the numbers will be relatively small—indeed, this might be quite unlikely to happen—but we should bear it in mind that APMS contracts do not require a GP to be a contract holder. They do not offer the same benefits to an ICB as a general or personal medical services contract holder, who is contractually required to be a GP. That is a significant difference. This position on the board should bring important perspective; it should not be wasted.

This is about two things: first, showing the best possible voice and secondly, putting a stop on creeping privatisation. Ministers have been at great pains earlier in the process, and certainly on Second Reading, to say that this is not about privatisation. Well, this is a very good chance to prove that.

5 pm

Justin Madders: I would like to speak to amendment 33, which is grouped with amendment 30. I will try to address the real concerns that were so eloquently described by the British Medical Association. It said that there are huge risks and absolutely no benefits from having out and out private companies sitting on integrated care boards. Nothing in the Bill remedies that conflict to allow those companies to sit on integrated care boards at the same as allowing them to comply with their statutory duty to their shareholders in manner that anyone could feel comfortable about.

We know that spending in the private sector before the pandemic in 2019-20 was £9.7 billion. I accept that those figures before the pandemic are probably the fairest to cite, but that sum is still double what it was a decade earlier under the last Labour Government. We have seen the creep from the private sector in recent years and we need to put an end to that.

Amendment 33 is not about the amount spent on private providers but about who runs the NHS, not just who profits from it. For us, there is a complete and utter incompatibility between the aim of a private company and what we say should be the aims of the NHS and ICBs. I can do no better than refer to the evidence of Dr Chaand Nagpaul, who last week said:

"We forget at our peril the added value, the accountability, the loyalty and the good will that the NHS provides. We really do.

We only have to look back at the last year. Compare the vaccination programme run by the NHS and delivered by NHS staff to Test and Trace. Even with Test and Trace, compare the £400 million that Public Health England had to the billions that went to the private sector, and local public health teams reached 97% of contacts compared to 60% for the others. I am saying that it does matter. Your local acute trust is not there on a 10-year contract, willing to walk away after two years. It is there for your population; it cannot walk away." —[*Official Report, Health and Care Public Bill Committee,* 9 September 2021; c. 90, Q113.]

Those final words sum up our concerns perfectly. Put a company on the board and their interests last as long as their contract. Of course, their interests may not be the same as the NHS's during that period anyway. With that clear and, we believe, unanswerable concern about conflicts of interest there must be a solution in the Bill. As it stands, there is not, and that is what amendment 33 seeks to remedy. We hope that the Minister recognises the opportunity that this presents and goes one step beyond his colleague, Lord Bethell, who said in response to a written question:

"We do not expect independent providers to have seats on the ICB."—[*Official Report, House of Lords,* 18 August 2021; Vol. 814, c. 56.]

What he expects and what is actually in the legislation is not the same.

We have already seen in the south-west private providers lining themselves up to have a big say in how local NHS systems are run. If it is the Government's position that they do not expect private companies to sit on the board, do they say that because they do not believe it

will happen, or because they do not want it to happen? If they do not want that to happen, they should support the amendment. If they do not support it, and if they refuse to join us in trying to legislate to stop private companies getting involved in the running of the NHS, all the people who believed that the Government were determined to increase private sector involvement in the NHS will be entitled to say, "We must be right."

When presented with the opportunity to put a halt to further private involvement, not only did the Government not support the proposals from Labour, but they actively voted against them. All the words about what the Government expect will count for nothing because when it comes to the crunch, the Government will have sided with the private companies, some of which, let us not forget, have actually sued the NHS when they have not got their own way. Is that the kind of collaboration and integration that we want to see in ICBs? Remember when Circle walked away from Hinchingbrooke because the contract was too tough. Was that in the spirit of joint working? No, it was not. We should be absolutely clear in this Committee and support the amendment that says that private companies should not be running or having a say in the running of ICBs.

The Chair: I suspend the sitting until after the Division.

5.4 pm

Sitting suspended for Divisions in the House.

5.32 pm

On resuming—

Dr Whitford: Although this was described as an evolutionary piece of legislation that would not involve a lot of upheaval for the NHS, it actually does. It is a significant piece of legislation, but it represents a missed opportunity to go back to a unified public NHS with integrated care bodies as the main structure. They are responsible for spending billions of pounds of public money, but the system will still be a transactional one based on a purchaser-provider split and tariffs. We will talk further about how can inhibit development.

If we are to have a purchaser-provider split, we have to have a split. We cannot get away from the conflict of interest inherent in having private providers who seek contracts to deliver care sitting on the very board that makes those decisions, or on the partnership board that will develop the strategy. That is a conflict of interest. It should be resolved, and the amendment should be supported.

Edward Argar: With your indulgence, Ms Elliott, I will turn to amendment 33 first. Integrated care boards will be NHS bodies, whose membership consists, at a minimum, of individuals appointed by NHS providers, providers of GP services and local authorities that coincide with the ICB. Any perceived risk of privatisation through the ICB membership provisions is, I believe, entirely unfounded—and, I feel bound to add, potentially unfair to the many public servants in the NHS who work for ICBs. Although service provision—I emphasise the word "provision"—by the independent and voluntary sectors has been, and continues to be, an important and valuable feature of this country's healthcare system under successive Governments of all political complexions, it was never the intention for independent providers, as corporate entities, to sit on integrated care boards, nor for an individual to be appointed there to be a representative of such an interest in any capacity.

People must therefore be assured that the work of integrated care boards is driven by health outcomes, not by profits, and I am sure that there will be a consensus on that principle across this Committee. That is why there are already safeguards in place to ensure that the interests of the public and the NHS are always put first. The ICB chair has the power to veto members of the board if they are unsuitable, and NHSE has the power to issue guidance to ICBs in relation to appointments as part of its general guidance-making power. That sits alongside the robust requirements on ICBs to manage conflicts of interests, and NHSE's wider duty to issue guidance to ICBs.

I turn to amendment 30, which seeks to exclude individuals whose GP practice holds an alternative provider medical services contract from being made a member of an ICB. APMS contractors include some private and third-sector organisations, but also some GP partnerships. These contractors include, for example, social enterprises and partnerships that provide services to homeless people and asylum seekers. This amendment would potentially prevent some individuals from being on ICBs, on the basis of the type of NHS GP contract that their practice holds.

I do appreciate the intent behind the amendments, namely the desire to avoid the appearance, and potentially even the risk, of privatisation and conflicts of interest. However, the effect would be to limit the ability of primary medical service providers to appoint an ICB member who might best meet the requirements of the local population, by reducing the diversity of GPs who could be appointed. While I can understand the intent behind them, I fear that these amendments do not do what they seek to do, and they would have unintended consequences. I will turn to those shortly.

We recognise that the involvement of the private sector, in all its forms, in ICBs is a matter of significant concern to Members in the House, and we are keen to put the point beyond doubt. However, having taken appropriate advice, I am afraid that that these amendments would not cover a number of scenarios—for example, lobbyists for private providers, or those with a strong ideological commitment to the private sector—and they would therefore not be watertight

As it stands, these amendments may well not offer the robust assurance that perhaps hon. Members intended. Therefore—this is where I may surprise the hon. Member for Ellesmere Port and Neston—to put this matter beyond doubt, we propose to bring forward a Government amendment on Report to protect the independence of ICBs by preventing individuals with significant interests in private healthcare from sitting on them.

As hon. Members will know from their attempts to draft these amendments, avoiding unintended consequences is not a simple matter. If appropriate, I would be happy to engage with either the hon. Member for Nottingham North or the hon. Member for Ellesmere Port and Neston in advance of Report. We may not reach a consensus, but, as they both know, I am always happy to have a conversation with them.

[Edward Argar]

The Government are firmly committed to the founding principles of the NHS. We recognise the importance of its values, and the public service ethos that animates it. It is by no means our intention to allow private sector providers to influence, or to make, decisions on spending on the commissioning board—the ICB—and the spending of public money. The Bill does not allow that, but we will look to see whether we can find a way to put that unfounded fear to bed once and for all with an appropriately worded amendment that does not have unintended consequences.

Although I appreciate that much the same motive underpins amendment 27, it is worth considering why the integrated care board and the integrated care partnership are different bodies. The decision to create integrated care partnerships came from discussions with a number of stakeholders who revealed a strong case for the creation of a committee to consider strategically not only the health needs but the broader social care and public health needs of a population. It is not a body like the ICP, as we have heard, which will be directly accountable for the spending of NHS monies.

We therefore do not intend to specify membership for the ICP in the Bill, as we want local areas to be able to appoint members as they think appropriate. To support that, we have recently been working with NHS England and the Local Government Association to publish an ICP engagement document setting out the role of integrated care partnerships and supporting local authorities, integrated care boards and other key stakeholders to consider what arrangements might work best in their areas.

We would expect members of the ICP to be drawn from a very wide variety of sources and backgrounds, including the health and wellbeing boards within the system; partner organisations with an interest in health and care, such as Healthwatch; and potentially voluntary and independent sector partners and social care providers at that level, as well as organisations with wider interests in local priorities, such as housing providers.

To exclude independent providers from both the ICB and the ICP would, I fear, risk severely reducing the extent to which all parts of the broader health and care ecosystem could be drawn upon in the ICP context. It would exclude valuable expertise and would, for example, prevent social care providers who provide a small amount of domiciliary care to the NHS from sitting on the ICP. Furthermore, the ICP will not make commissioning decisions or enter into contractual arrangements that are binding, or make decisions about who gets funding allocations. Those are functions conferred on the ICB, hence the distinction that I make.

I therefore believe that membership of individuals from independent providers on the ICP does not present a conflict of interest in the way that hon. Members have asserted, certainly in the context of the ICB. I suspect that we may debate that further in the coming weeks, but taken with the ICB and the comments that I have made, we believe that this provides the right balance between recognising the distinctive accountabilities and responsibilities of the NHS, local authorities and other partners, and strongly encouraging areas to go further in developing joint working.

I hope that what I have said provides some reassurance to Opposition Members, and that they will be willing—I see them nodding—to engage with me to see whether we might find a greater degree of consensus. I should also say that I will obviously speak to the Scottish National party spokesperson on this as well, as I have done throughout. I addressed my remarks to the shadow Minister, but of course I extend that offer to her. I hope that on that basis, the Opposition Front-Bench spokesman will consider withdrawing the amendment.

Alex Norris: If the Bill is about collaboration, we ought to model that here. Given that very gracious offer, I am very happy to beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

The Chair: We now come to amendment 33 to schedule 2, which has just been debated. Justin Madders, do you wish to move the amendment formally?

Justin Madders: In the light of the Minister's concessions, we wait with interest to see what we can work together on to achieve the aim that appears to be shared across the Committee, so we will not move amendment 33.

Ordered, That further consideration be now adjourned.—*(Maggie Throup.)*

5.42 pm

Adjourned till Thursday 16 September at half-past Eleven o'clock.

Written evidence reported to the House

HCB60 Mental Health Policy Group

HCB61 Royal College of General Practitioners

HCB62 Royal College of Physicians

HCB63 National Pensioners Convention

HCB64 First 1001 Days Movement

HCB65 Urology Trade Association

HCB66 Faculty of Sexual and Reproductive Healthcare (FSRH) and Royal College of Obstetricians and Gynaecologists (RCOG) (joint submission)

HCB67 Cancer Research UK

HCB68 NHS Providers

HCB69 The British Medical Association, British Dental Association, Pharmaceutical Services Negotiating Committee, Optometric Fees Negotiating Committee and National Community Hearing Association, on behalf of NHS Primary Care (joint submission)

HCB70 Centre for Governance and Scrutiny