PARLIAMENTARY DEBATES

HOUSE OF COMMONS
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GENERAL COMMITTEES

Public Bill Committee

HEALTH AND CARE BILL

Eighth Sitting

Thursday 16 September 2021

(Afternoon)

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Monday 20 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

Thursday 16 September 2021

(Afternoon)

[Julie Elliott *in the Chair*]

Health and Care Bill

Clause 15

Commissioning hospital and other health services

2 pm

The Minister for Health (Edward Argar): I beg to move amendment 12, in clause 15, page 13, line 22, at end insert—

"(ba) medical services other than primary medical services (for primary medical services, see Part 4),".

This amendment makes it clear that integrated boards have a duty to commission secondary medical services (replicating the current position for clinical commissioning groups). Although secondary medical services would appear to fall within new section 3(1)(f) and (g), in the existing legislation they are mentioned specifically so the amendment would continue that approach.

The Chair: With this it will be convenient to discuss Government amendment 13.

Edward Argar: It is a pleasure once again to serve under your chairmanship, Ms Elliott. Government amendments 12 and 13 are both technical amendments that clarify the commissioning responsibilities of integrated care boards. Clause 15 introduces proposed new section 3 of the National Health Service Act 2006, which places a duty on integrated care boards to commission a range of non-primary health services. The duty to arrange for the provision of primary care is dealt with elsewhere in the Bill.

In the Bill as introduced, there was no specific reference to medical services. Instead, non-primary medical services were considered to be covered by the broad provisions of new section 3(1)(f) and (g), and primary medical services were dealt with elsewhere in the Bill. Similarly, there was no specific reference to ophthalmic services. Instead, non-primary ophthalmic services were considered to be covered by the broad provisions of new section 3(1)(f) and (g), and primary ophthalmic services were dealt with elsewhere in the Bill.

However, the equivalent duties for clinical commissioning groups specifically reference these medical services and ophthalmic services, so the removal of an express reference to non-primary medical services and ophthalmic services generated some concern, which I hope to reassure the Committee is misplaced. There is no change of policy in this area, but to avoid any potential confusion these amendments put beyond doubt the fact that integrated care boards are responsible for these services, and replicate the current language.

Justin Madders (Ellesmere Port and Neston) (Lab): We will not oppose the amendments or, indeed, clause 15. I think it is important, as the Minister said, to make it very clear that the relevant provision in clause 15, proposed new section 3(1), on ICBs providing services that they consider necessary, does not mean that they can unilaterally withdraw services. That is the concern that has been raised, and I think it is important that it is on the record that that is not what is intended.

Jo Gideon (Stoke-on-Trent Central) (Con): It is a pleasure to serve under your chairmanship, Ms Elliott. I seek some clarification. With demand for palliative care set to soar because of our ageing population, I would be very grateful for any assurances that my hon. Friend the Minister can give that the reference in clause 15, in line 30 on page 13, to "after-care" includes palliative care and end-of-life care services.

Mary Robinson (Cheadle) (Con): In supporting my hon. Friend the Member for Stoke-on-Trent Central, I also ask our hon. Friend the Minister to clarify this matter. As we all know, the voluntary sector is hugely important for palliative care. So many people at the end of life want to go home. We also know, in relation to discharge from hospital, that we need to get people into the right place, with the right care, so it is hugely important that we do everything we can to support that sector and to relate it to end-of-life care and palliative care.

From a personal and local perspective, I will also say, on the care that is provided, that my constituency has an excellent hospice—St Ann's hospice. It is celebrating its 50th anniversary this year, and lots of events are taking place. The hospice relies on funding from donations from local people and the wider public. It does an enormous amount of work.

If we are to provide the personalised care that we want to achieve, and if we are to enable people to be at home and to be cared for in different settings at the end of their life, it is really important that we consider this matter in relation to the Bill, so I welcome this change to clause 15.

Edward Argar: A number of the points raised by hon. Members, while touching on the amendments, will be addressed substantively in the clause stand part debate that is just about to take place. I do not think that there is anything further to add on the amendments.

Amendment 12 agreed to.

Amendment made: 13, in clause 15, page 13, line 24, at end insert—

"(ca) ophthalmic services other than primary ophthalmic services (for primary ophthalmic services, see Part 6),".—*(Edward Argar.)*

This amendment makes it clear that integrated boards have a duty to commission secondary ophthalmic services (replicating the current position for clinical commissioning groups). Although secondary ophthalmic services would appear to fall within new section 3(1)(f) and (g), in the existing legislation they are mentioned specifically so the amendment would continue that approach.

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

Edward Argar: In opening the debate on this clause, I highlight the contributions made by my hon. Friends the Members for Stoke-on-Trent Central and for Cheadle. I suspect that, in my winding-up speech, I may be

responding to further questions on this. They are absolutely right to highlight the amazing work that is done by hospices and various charities and organisations in providing end-of-life and palliative care. When I come to my conclusions, I hope to be able to offer further reassurances to my hon. Friends, who I know take a very close interest in this area, and, quite rightly, have championed it in the Committee today.

Clause 15 substitutes a new section 3 into the National Health Service Act 2006, which replaces the clinical commissioning group equivalent with one that requires integrated care boards to commission hospital and other health services for those persons for whom the ICB is responsible. The clause lists those things that the ICB must arrange for the provision of, which includes, but is not limited to, hospital accommodation, nursing and ambulance services, dental services, diagnosis, care, treatment and aftercare of people suffering illness, injury or disability. In proposed new section 3A, the clause also provides a power for ICBs to arrange for other services or facilities that they consider appropriate to secure improvement in the physical and mental health of people for whom they are responsible.

The clause makes it clear that the duty on an ICB to arrange services does not apply if NHS England has a duty to arrange for their provision. The clause gives ICBs a clear purpose, without which it would not be obvious which bodies in the system are responsible for commissioning which parts of the comprehensive health service that we all want to see.

I should note that ICBs will not be the sole commissioner in the system. As I have just alluded to, NHS England will remain a commissioner for some services best commissioned nationally, such as specialised services. The clause also allows us to very clearly divide responsibilities between NHS England and ICBs. Between NHS England and the ICBs, the NHS will continue to commission a comprehensive health service free at the point of delivery for all who need it. I therefore commend the clause to the Committee.

Karin Smyth (Bristol South) (Lab): I rise to support the comments that were made earlier. I had indicated to the Minister that I would raise the issue about stating very clearly that the terms "care" and "after-care" in proposed new section 3(1)(f) include palliative care and services at the end of life. We have had a 36% rise in the number of people dying at home during the pandemic. That may be a result of choice, but, as someone who has supported someone at the end of their life at home, it is only possible through end-of-life services, including GP services and the Marie Curie overnight nurse. I do worry desperately about the percentage of people who are dying at home. It will be a huge issue for these organisations in the future to manage that positively. The Minister's assurance that palliative care and end-of-life services are very much the responsibility of these boards would be most welcome.

Edward Argar: I will respond only briefly, because the only outstanding point that the hon. Lady rightly made was about paragraph (f). My understanding is that palliative care services and similar, as she has alluded to, would be captured under that paragraph. She is right, as are other Members, to highlight just how important those services are as continuing care or aftercare for patients. I give her the reassurance that my understanding of paragraph (f) is that it would encompass the services to which she has alluded.

Karin Smyth: Thank you.

Question put and agreed to.

Clause 15, as amended, ordered to stand part of the Bill.

Clause 16

COMMISSIONING PRIMARY CARE SERVICES ETC

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

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

Amendment 28, in schedule 3, page 126, line 28, leave out "person" and insert

"general practitioner, GP partnership or social enterprise providing primary medical services".

This amendment would prevent an integrated care board from entering into or renewing any Alternative Provider Medical Services (APMS) contract.

Amendment 29, page 126, line 32, leave out "person" and insert

"general practitioner, GP partnership or social enterprise providing primary medical services".

This amendment would prevent NHS England from entering into or renewing any Alternative Provider Medical Services (APMS) contract.

That schedule 3 be the Third schedule to the Bill.

Clause 17 stand part.

Edward Argar: With your permission, Ms Elliott, I will first turn to clause 16 and schedule 3, and then discuss amendments 28 and 29, before concluding with clause 17.

Clause 16 gives effect to schedule 3, which makes provision for integrated care boards to take on responsibility for primary care services. The schedule allows for the conferral of functions relating to the commissioning of primary medical, dental and ophthalmic services on ICBs and contains related amendments. NHS England is currently responsible for arranging these services, but in future, once ICBs are fully established and ready to take on these functions, we intend for ICBs to hold the majority of them. This approach will ensure that decisions about services are made closer to the patient and in line with local population needs.

The schedule introduces a number of provisions to enable the transfer of these functions. The schedule includes equivalent provisions relating to primary medical, dental and ophthalmic services. That is to ensure flexibility, as it allows the different services to be conferred on ICBs over a period of time if that is deemed the most effective and efficient approach. The Bill is designed for the future, and we want to work with the system to support it to move at the right pace and offer patients the best care at all times.

The schedule provides for regulations to define which services should be regarded as primary medical, dental and ophthalmic services for the purposes of the Bill.

[Edward Argar]

The services that are classed as primary care services may vary over time and so these powers allow the Secretary of State to react to any such changes. The powers restate similar powers that are currently found in the National Health Service Act 2006. This provision places a duty on ICBs to provide primary medical, dental and ophthalmic services for those people for whom the ICB is responsible and allows ICBs to enter into the necessary arrangements in order to do so. To date, NHS England has always been responsible for dental and ophthalmic services, but the commissioning of primary medical services has been successfully delegated to clinical commissioning groups for some time. These provisions will ensure that primary care continues to be at the centre of delivering joined-up care to local communities—many members of the Committee have highlighted that—in partnership with wider health and care services in the area.

The schedule requires each ICB and NHS England to publish any information that may be prescribed in regulations concerning the provision of primary medical, dental and ophthalmic services. To ensure that appropriate safeguards are in place once these responsibilities are transferred, NHS England will have powers to direct ICBs as to how they should exercise their primary medical, dental and ophthalmic care functions.

In addition to primary care services, the Secretary of State will have powers to require NHS England to exercise pharmaceutical services, which can, in turn, be delegated to the integrated care boards. NHS pharmaceutical services are generally not directly commissioned, and the schedule continues to allow for that consistent approach to be followed.

The schedule makes provision for the necessary technical and consequential amendments to reflect the new provisions within it relating to primary care services. It is crucial for establishing ICBs as the key commissioners for the NHS in England in the future.

I am grateful for the opportunity to debate amendments 28 and 29. I will address what I read into them at this stage and if I have misrepresented them, I will of course seek at the end, as appropriate, to address any misapprehensions I may have set out. I fear that the amendments would prevent an ICB from entering or renewing a contract with some private and third-sector organisations for the provision of primary medical services. Although the explanatory note for the amendment says this will

"prevent an integrated care board from entering into or renewing any Alternative Provider Medical Services (APMS) contract",

I have been advised that it would actually go much further than that limited objective, as limited companies can currently also hold general medical services and personal medical services contracts. The amendment would bar some of those companies from doing so, which would have a potentially devastating effect on primary care at a moment when the Under-Secretary of State for Health and Social Care, my hon. Friend the Member for Bury St Edmunds, is working flat out to build capacity in primary care.

2.15 pm

My constituency neighbour, the right hon. Member for Leicester South (Jonathan Ashworth), has accused the Government of allowing, in his words, the "stealth privatisation" of primary care and thereby undermining patient care. However, primary care commissioners have long had a choice to commission services from a range of primary care providers. Prior to the introduction of CCGs, primary care trusts had a long-standing power under section 23 of the National Health Service Act 1977, which was introduced by the Labour party, to purchase services from the independent and voluntary sector. If I recall correctly, it was the Labour party that, in 2004, first allowed GP out-of-hours services to be contracted to private companies.

It is crucial that commissioners have the flexibility to commission partnerships, individuals, and private and third-sector organisations to deliver NHS GP services to meet the specific healthcare needs of their populations. Private and third-sector providers play a vital role in the delivery of services to meet those needs, and they must adhere to the same quality and safety standards as any other form of GP contractor. The Labour Front-Bench team will know that we have moved to have further discussions with them on ICBs—hopefully, that will be a positive step forward—but in this case, we cannot support the amendments.

Let me say a few words about APMS contracts. Such contracts offer greater flexibility than either GMS or PMS contracts, for the benefit of both commissioner and provider. APMS contracts are time-limited and can be locally negotiated and used to commission other types of primary care service beyond core general practice. Because of their flexibility, APMS contracts allow commissioners to commission specific primary medical care services in response to specific local need. I fear that the amendment would undermine commissioners' ability to commission services fully to meet the needs of their local populations in a flexible way at, as I said, exactly the same time as the Under-Secretary of State for Health and Social Care is working to encourage them to go further in the development and design of high-quality primary care services.

I suspect that the shadow Minister, the hon. Member for Nottingham North, will clarify matters if I have misunderstood some elements of his proposals, but I have set out my current misapprehensions on the basis of what is in front of me. I hope he will rethink and consider not pressing the amendments to a Division, given our concerns about the potential negative impact on the provision of primary care.

Finally, let me turn briefly to clause 17 which, importantly, provides a power to make transfer schemes in preparation for the time when ICBs take on primary care functions, by enabling NHS England to transfer property rights and liabilities to ICBs. The rights and liabilities that can be transferred under the clause include those in relation to a contract of employment, thereby ensuring a smooth transition to the new commissioning arrangements. Without the clause, we would risk the creation of instability for NHS staff and the possibility that ICBs could lack the necessary rights, staff and property effectively to commission primary medical, dental and ophthalmic care. I therefore commend clauses 16 and 17 and schedule 3 to the Committee.

Alex Norris (Nottingham North) (Lab/Co-op): It is a pleasure to serve with you in the Chair, Ms Elliott. I wish to speak to amendments 28 and 29, and will also briefly address a couple of brief points relating to the clause.

I am grateful for the Minister's response—it is handy to know in advance the likely arguments against the amendments. I referred to the amendments late on Tuesday afternoon, with regard to private company involvement in integrated care boards. We are heartened to hear what the Minister said about that and look forward to having those conversations. My original notes said that the amendments go a little further and might be a little rich for the Committee's blood, and that may well be the case, but they are nevertheless important.

As I said the other day, the vast majority—around 70% —of GP services are provided on the general medical services contracting model, between local and national commissioners and a GP or GPs and their practice. A little more than a quarter of services are on the personal medical services terms, which allow greater local flexibility, although I understand that the intention is to phase them out. There is a small but growing number of APMSs, which we are debating. APMSs allow bespoke contracting with private companies, with no obligation for a GP behind them. The Minister mentioned their being time-limited as an asset; I am not sure that that is necessarily true. Of course, there has to be flexibility for commissioners to meet need, but my argument is that this is being misused and is operating as a loophole for private companies to enter the market and cream off profits in a way that I do not think is generally the direction that service users in the NHS want. Colleagues should not think that, because the model currently provides just over 2.5% of contracts, this is in some way small beer. The largest provider of GP services in this country is wholly owned by a US megacorporation and has 500,000 patients on its books. I do not think that is what our constituents want from their national health service in England, and I do not think that is what they expect it to look like either.

Therefore, it is reasonable to use the Bill to try to do something about it, because this will be the model. It will grow at pace unless it is checked, and there are many reasons to tackle the issue. It is not just because I find the model distasteful, which I do. First, such contracts are poor value for money. For a registered patient, the mean payment to an APMS provider is 11% greater than that to a GMS provider. Of course, the Minister made the argument on Tuesday that such practices often serve the hardest cohorts, so perhaps that could account for the difference, but that is not the case either. When patients are weighted according to need, the mean payment is actually 16% greater on APMS contracts—it gets worse. If we read that across the entire patient list across the country, it would be the equivalent of £1.5 billion. That is the risk, if this grows to be the dominant model. Such contracts also provide less satisfactory care, with a 2017 survey of nearly 1 million patients finding that APMS services generated lower levels of satisfaction.

Finally, the contracts are easier to walk away from. Within the NHS, we already know that when it stops working for private providers corporately, they are willing to just walk away from contracts and hand them straight back. I strongly say to the Minister that such arrangements are a distortion of the health service's founding principles. They are costly, they are of lesser quality and they are less reliable.

Amendment 28 is designed to stop integrated care boards entering or renewing such contacts, and amendment 29 would do the same for NHS England. I fear that the Minister may have slightly catastrophised the impact of that, because if this was accepted today, there would be GP services that could no longer operate tomorrow. For a start, the Bill has an awful long way to go, and I gently say that if there is anxiety about health organisations working in advance and presupposing that this will become law at some point and will be operational in April, I am afraid that the Government started that a very long time ago and have already started to fill places in shadow. I do not think there should be any anxiety about getting prepared in this way, so that there would not be a cliff edge.

I am willing to take the argument that perhaps there is a better and more elegant way of drafting this, and I would happily accept an amendment in lieu, but what I cannot accept is nothing at all. Again, the Minister's point on Tuesday was very good, because sometimes there will need to be a way to provide flexibility for very bespoke services. I think the example he used was services for street homeless people. Of course, that might be a very different model from that of the GPs on my estate. I would accept that as a principle, but the corporation that has the biggest patient list, at 500,000, is a bricks-and-mortar primary care service in my community. That is not a use of flexibility; it is using that as a loophole.

I do not think that can be right, and I do not think the answer can be that the provision needs to exist and therefore we must open this space for that sort of distortion. We are either saying, "There needs to be flexibility, and here is the best way of having a flexible system. Don't worry—we'll make sure it is not misused," or we are saying that we are happy with such organisations entering the market. The Government need to say which one is their preference.

I will make a point about primary care networks before I move on to clause stand part. Obviously, primary care networks are not in the Bill, but I put quite a lot of stock in them. I think that, locally, they will be a very important unit of organisation of care services in our community. I want them to work, and I am playing an active role in the primary care network in my constituency. I think they have real potential. However, who will lead them if we lose our GP practices to those who do not have an interest in our community? The model will become much more distant and uninterested, based on finances rather than the local population. I believe that would be a very, very bad thing indeed. As I say, the amendments may not offer the best way to close that loophole, but I have not heard a better one, or indeed a desire to close it, so I wish to press the amendments to a Division.

Finally, a couple of quick points on schedule 3, which we do not intend to press to a Division. We have had quite a lot of discussion—the Minister touched on this in the previous stand part debate—about the arrangement of integrated care systems, such as they exist. At the moment, we know that NHS England holds certain responsibilities, the regional teams hold certain responsibilities and CCGs hold certain responsibilities at a local level. It is possible, after these reforms, that CCGs will be replaced by ICBs and the previous arrangements and responsibilities will remain unchanged,

[Alex Norris]

with NHS England nationally doing the same things, the regional teams doing the same things and ICBs picking up the responsibilities of their predecessors. I suspect, however, that that is not the intention, so I want to press the Minister a little bit on that.

The explanatory notes, on page 59, paragraph 286, state that the functions relating to medical, dental and ophthalmic primary care sit with NHS England, but that

"The intention is that Integrated Care Boards will hold the majority of these functions…in the future."

Will the Minister expand on that? Does a "majority" mean two out of the three in a different area? Does he intend—again, we touched on this the other day—that this should all be devolved to the 42 ICBs at the same time, or will there be a sense of when each system is ready to pick up those important services? If so, what criteria will that be based on?

Finally, in case we do not come back to this topic—I do not expect the Minister to have an exhaustive list to hand—what is the thinking on other NHS England national and regional functions? Are they likely to be devolved to ICBs? Can he give an example of what sorts of things might be retained? He mentioned that we would want to retain specialist commissioning at a national level. The final question is this: is it ICB by default unless there is a very good reason why it cannot and therefore it has to be done at a national level, or is it at a national level unless it is proven that ICBs are competent to take it on? The answer may be a bit of a mixed economy, but if that is the case, I am keen to know what criteria he will use, or the Secretary of State will use, to make those decisions.

Karin Smyth: I rise to support my hon. Friend the Member for Nottingham North, who made an excellent case for amendments 28 and 29. While on a primary care trust board, I commissioned APMS contracts under a previous magnificent Government—I am not saying this one's not magnificent, but—because they offered flexibility. Then, as now, they were a sign of a failure of the system and the model of primary care contracting to deliver, particularly in areas of high deprivation. To provide flexibility in Bristol, for example, we had an 8 am to 8 pm service in the city centre to allow better access for people in the city centre, partly to drive down demand on emergency care services, which is a circle that we just keep on going round. Whether they worked or not is a bit of moot point, but it is a model and it is clear that something is needed—I would certainly concede that—so I understand the Government's difficulty here with having something that is flexible.

I was slightly concerned when the Minister said that the APMS model would be developed further. I wonder if he wants to come back on that. We have to accept that they are problematic at the moment and we would like to see them go because of that. They are now being used as a back door, a very unfortunate one, for large private companies to start hoovering up general practices, which is, yet again, a sign of failure as to why they cannot survive in their environment. If they are going to be developed further, that is something we would like to hear more about. If not now, perhaps the Minister responsible could come back to us on that. Patients are always surprised when they find out that their GP is a private contractor. I accept that this is a difficult area to be completely black and white on. We are certainly in favour of flexibility in developing services in areas of high demand where, for reasons around capital or the type of contract, a GP might enter into partnerships. We know that the workforce is changing rapidly and the model of partnerships is not as attractive and is not recruiting people into the service. It is—not to overuse the word—a crisis.

I am sure we have all been contacted by various bodies representing GPs in our own constituencies. They are fearful not just about the current pressures, but the future attractiveness of primary care. We are not going to get into the future model of the contract today, but I always pity the poor Minister who has to negotiate the contract.

2.30 pm

Edward Argar: I fear she is sitting behind me.

Karin Smyth: It is not a negotiation that anyone looks forward to with relish, but we need to take a good, strong look at the model now. This policy is not the route, and my hon. Friend the Member for Nottingham North has described perfectly why it is not. It is of deep concern. These large organisations are not part of the local community. It is completely against the thrust of this Bill, which is about place-based, locally accountable systems. The Government would be wise to take his advice and perhaps come back with something else. We seek assurance that this policy is not being developed further, because that would be of even greater concern.

Edward Argar: I can reassure the hon. Member for Bristol South. I fear she misheard me when I was saying that we were encouraging primary care commissioners to go further in developing primary care provision—that was not necessarily this model. Forgive me if I was unclear on that, and I hope that gives her a little reassurance on that point.

To address a number of the other points that the shadow Minister primarily made, I suspect his fears are not borne out in reality. I suspect he will none the less, as we cannot accept his amendment, press it to a vote to highlight the issue, and that is his prerogative. I come back to the point that flexibility in this space is hugely important. The examples given by the hon. Member for Bristol South about the challenges in primary care provision are a good argument for why we need this flexibility. We know that some practices, which are GPs' private businesses contracted to the NHS, on occasion will collapse or a partner will retire and a surgery will cease to operate, especially if no one wishes to take it over. Therefore it is important that these flexibilities are available to commissioners to ensure GP practice coverage.

Karin Smyth: Just to be clear—my apologies for mishearing the Minister previously—such closures are a sign of failure. The answer is to negotiate the contract better and to modernise a clear contract, not to use this vehicle. That was my very clear point.

Edward Argar: I take the hon. Lady's point, but it would be a sign of failure not to build flexibility for all eventualities into the arrangements we have at the disposal of commissioners and into what my hon. Friend the Member for Bury St Edmunds is trying to do to build

resilience into the system. I very much hope that she will continue to do so, or will ascend in the next few hours to something else. That is why flexibility is at the heart of this measure and why we cannot support the amendment of the hon. Member for Nottingham North.

I will try to address a couple of points that the hon. Gentleman made. We envisage PCNs continuing to play a hugely important role locally in the provision of primary care services. My GP is actively involved in the local PCN in Leicestershire. I know, whenever I speak to him, just how much it has done, particularly in the past 18 months, to build resilience into the system and make sure it works. I know the value of those PCNs more broadly in, for want of a better way of putting it, more normal times.

The final thing the hon. Gentleman asked about was the delegation of currently nationally commissioned functions down to ICBs. The short answer is that he was right in his supposition that this is not a binary, one-size-fits-all measure. The reality is that NHS England will be looking at which ICBs and ICS areas are sufficiently developed that they can take on additional commissioning responsibilities. If he and I sat down, we would probably have a fair sense of which ones were already well advanced. It may be some where there is a mayoralty and there is already a significant amount of devolution in one or two areas. It may be others. We heard from Dame Gill Morgan in Gloucestershire, who clearly has a highly developed ICS in that area. I would be reticent about setting a black-and-white thing on meeting some criteria. There is a degree of subjectivity, which is why we will be reliant on the expert advice of our colleagues in NHS England, and they will make these decisions in the appropriate way.

I hope that gives the hon. Gentleman some reassurance on the broader clauses and schedule stand part. I fear I have not persuaded him in respect of his amendments, but it was worth a try.

Question put and agreed to.

Clause 16 accordingly ordered to stand part of the Bill.

Schedule 3

CONFERRAL OF PRIMARY CARE FUNCTIONS ON INTEGRATED CARE BOARDS ETC

Amendment proposed: 28, in schedule 3, page 126, line 28, leave out "person" and insert

"general practitioner, GP partnership or social enterprise providing primary medical services".—*(Alex Norris.)*

This amendment would prevent an integrated care board from entering into or renewing any Alternative Provider Medical Services (APMS) contract.

The Committee divided: Ayes 5, Noes 9.

Division No. 7]

AYES

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

NOES

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

Question accordingly negatived.

Schedule 3 agreed to.

Clause 17 ordered to stand part of the Bill.

Clause 18

COMMISSIONING ARRANGEMENTS: CONFERRAL OF DISCRETIONS

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

Edward Argar: Clause 18 amends section 12ZA of the NHS Act 2006, which currently relates to commissioning arrangements by the board and the CCG. Elsewhere in the Bill, this has been updated to refer to newly merged NHS England and ICBs instead. The purpose of the clause is to allow those arrangements to be efficient and work smoothly so that ultimately patients are provided with the best service.

In essence, the clause would allow NHS England and integrated care boards to choose to enter more flexible arrangements with providers of NHS services, allowing flexibility for providers to tailor services to best meet the health needs of the population. For example, the management of long-term conditions such as diabetes can have complex care pathways. An integrated care board, through its commissioning arrangements, could allow a local trust to determine the range of services that will meet these needs in the local area. This includes the trust subcontracting services to other providers where they are best placed to provide some of those services.

The flexibilities provided by this clause will add to the ability of commissioners and providers to work together, using each other's expertise to get the best outcomes for the entire system. I therefore commend the clause to the Committee.

Question put and agreed to.

Clause 18 accordingly ordered to stand part of the Bill.

The Chair: We now come to clause 19, to which 15 amendments have been tabled. Although amendments 77 to 79, 4, 56, and 80 to 82 have not been selected for debate as no member of the Committee has signed them, if any Member wants to move those amendments, would they please indicate?

Clause 19

GENERAL FUNCTIONS

Justin Madders: I beg to move amendment 45, in clause 19, page 16, line 2, at end insert—

"(c) make arrangements to ensure that patients can access services within maximum waiting times in accordance with their rights in the NHS Constitution."

This amendment places a duty on each integrated care board, in the exercise of its functions, to meet maximum waiting time standards.

The amendment would insert in clause 19 a new requirement on integrated care boards, in addition to the many requirements set out in the clause, to ensure that patients could access services within the maximum waiting times as set out in the NHS constitution. I expect the Minister will tell us that those requirements are already set out in the constitution and that the amendment is therefore unnecessary, but if the answer is that that is an effective tool for ensuring compliance, by any account it has failed.

[Justin Madders]

In every aspect of performance, the NHS has gone backwards in recent years and there can be no doubting the strength of connection between that going backwards and the decade of austerity that the NHS has endured. It is more than five years since the 18-week standard has been met, and that has led to the record waiting lists we see now. In case there is any doubt about this, let me put it on the record that waiting lists were already at record levels before the pandemic, and despite all the fanfare from the Prime Minister following the national insurance rise, we still do not have a guarantee that they will go down during this Parliament.

Let us not forget why the last Labour Government introduced the standards. Years of underfunding under the 1979 to 1997 Conservative Government led us to a dark place. People were waiting months—sometimes years—to access treatment, and that was rightly identified as a priority to fix by the last Labour Government, who wanted to let record investment into the NHS, but also wanted to ensure that that investment was targeted and effective so that the NHS could be judged on its performance. As a result, the targets were introduced.

Targets and funding combined proved to be effective, which is why, by the time the Labour party left office, the NHS had record satisfaction levels and waiting times that today's Secretary of State can only dream of. Little wonder the rhetoric in recent months has increasingly been that of scepticism about the benefit of such targets, culminating in the Secretary of State's words at the weekend that the targets are, in fact, "nonsense". Well, I think we can see what is going on. Targets have got hopelessly out of reach and there is no real plan for to how to change that, so the Government seek to undermine and ultimately change—or remove altogether—the targets, so that poor performance is disguised or played down.

That does a disservice to the patients who are waiting months—in some cases, sadly, years—for the treatment that they are entitled to. Most of those people will be in significant pain. All will be unable to live their lives to the extent that they would like. Some may be unable to work or undertake other physical activities. We do not need to go through the full list; we can all understand the impact that waiting for treatment can have on individuals. In many cases, their lives are effectively put on hold. They deserve better. The amendment would make it clear that their rights as patients under the constitution meant something and that the ICBs should be expected to focus on delivering those standards.

Edward Argar: I am grateful to the shadow Minister for tabling the amendment and giving us the opportunity to debate it. Of course we understand the importance of reducing waiting times. The Government are committed to increasing activity, tackling backlogs and ensuring that patients can access timely healthcare, backed up by the record investment announced by the Prime Minister and the Chancellor—indeed, some might agree, to a degree copying what the Labour Government did in putting up national insurance.

For instance, to tackle backlogs and drive up activity, the Government are providing £2 billion of elective recovery funding, which is double our previous commitment, and we are working to encourage innovation to help patients to get the care they need. In his remarks, the shadow Minister highlighted funding. I would point out to him the fact that, despite inheriting a note saying "Sorry, there is no more money," we have continued to increase spending on the NHS.

2.45 pm

Let me turn to the specifics. The amendment would require all integrated care boards to make arrangements to ensure that patients could access services within maximum waiting times, in accordance with their rights. The NHS constitution—the shadow Minister was ahead of me—sets out the principles and values that underpin the NHS in England. It is a declaratory document, as the rights expressed in it are established by legislation that is independent of the constitution itself. It contains further pledges with which the NHS has committed to seek to comply as far as possible, but which, he would rightly say, are not legally binding.

The patient right on waiting times in the constitution encompasses both the 18-week referral to treatment standard and the two-week cancer standard, which are given statutory effect through regulations. A constitution pledge on waiting times encompasses a number of other non-statutory waiting time standards. The requirements in relation to waiting times provided for in the standing rules create a legal duty on the relevant NHS bodies to which they relate. That is in addition to the duty that all those who commission or provide services on behalf of the NHS have to have regard to the NHS constitution when exercising their functions.

The enabling power under which the standing rules regulations are made is being amended by the Bill to apply to ICBs. Amendments to regulations to confer the relevant duties on ICBs will also be made to coincide with the establishment of ICBs. Furthermore, it would not be appropriate to apply a requirement to ICBs in relation to all the waiting times in the NHS constitution, as some may fall, largely or partly, outside their control—for example, services commissioned nationally by NHS England. For those reasons, we cannot support the amendment, and I will try my luck in encouraging the hon. Gentleman to withdraw it.

Justin Madders: I am grateful for the Minister's vain attempt to persuade me to withdraw the amendment, although he rather missed the central thrust of its purpose, which is, of course, to point out that this is not just about funding; it is about focusing that funding. That is why the targets were introduced in the first place.

We believe it is important that ICBs are also given that focus; we could call it an incentive or a prioritisation. They should be keen to be seen to be delivering that. This is such an important part of the NHS—how are we to judge each ICB's performance if we do not know how they are performing on waiting lists? This is an important area. We think the general tone and the rhetoric from the Government are that waiting targets are not of significance, so this is an opportunity for them to put right some of the stories that go around in respect of that by supporting the amendment. We will press the amendment to a vote in any case because we believe that this is an important matter, and it should be put on the record.

Karin Smyth: I will not repeat my comments of the other day with respect to an amendment that suddenly disappeared from the amendment paper without my

noticing. The point I was making was that targets do drive behaviour, and we learnt something in that magnificent drive down from the Conservative Government's target of 18 months to wait on a list, which seemed acceptable to them at the time. The wait is beyond that now for many services, which seems acceptable to the Government now, although it is completely unacceptable to everyone in my constituency.

We must consider the managerial and clinical effort involved in focusing on those waiting lists, which, as I have said previously, is about making contact with all those patients, assessing their condition and seeing how it has ordinarily deteriorated once on the waiting list. Sadly, many people have died while on those waiting lists. That effort is huge, and it will require focus.

The Government are asking us all to pay a bit more towards the health service, and most of us are conscious of the fact that that is needed. We can debate how it is being done, but we should know what it will get us. We should absolutely be clear to our constituents—given that they have suffered so much, particularly during the pandemic—that the previous standards were not acceptable, and were not being met, and that it is completely unacceptable to ask people to pay more without their having any idea of what that will bring, or indeed of the Government's intent with regard to how long they think it is acceptable for people to be on a waiting list.

It is also hugely onerous on the clinical managerial staff to manage these waiting lists in the way that they are, which is hugely inefficient. This is a really bad sign of the flow through the system; we have bottlenecks throughout. It will come back to haunt the Government and whoever is speaking on their behalf at this time—I have no doubt about that. I say that with sorrow because it is miserable all round. The Government would be wise to make some kind of assessment of what they think is an acceptable time to wait for various treatments, so that would be clear to people. Supporting our amendment would give some indication of good faith, at the very least.

Justin Madders: My hon. Friend has described the amendment very well, and it would be good to know the Government's intentions in respect of waiting lists, because we consider the rhetoric a distraction and a nuisance. It is politically convenient for them to have such headlines. We want to put the amendment to the vote.

Question put, That the amendment be made.

The Committee divided: Ayes 5, Noes 8.

Division No. 8]

AYES

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

NOES

Argar, Edward	Gideon, Jo
Churchill, Jo	Robinson, Mary
Davies, Gareth	Skidmore, rh Chris
Davies, Dr James	Timpson, Edward

Question accordingly negatived.

Edward Timpson (Eddisbury) (Con): On a point of order, Ms Elliott. I apologise for interrupting the flow of the sitting, but it will not have escaped your notice that my amendments 55 and 54 to clause 20 are coming up soon. As luck would have it, the debate will coincide precisely with the time at which I am due in Westminster Hall to discuss the progress of the Government's implementation of the recommendations of the Timpson review. It is very difficult for me to avoid being present in Westminster Hall. As luck would further have it, my hon. Friend the Member for Vale of Clwyd is happy to move the amendments on my behalf, as well as speak to them. I hope that is acceptable, and I apologise for having to absent myself for a short period in order to fulfil my duties in another part of the House.

The Chair: That is absolutely fine. I thank the hon. Member for advising the Committee of that.

Justin Madders: I beg to move amendment 58, in clause 19, page 17, line 4, at end insert

"through working with innovation and life sciences ecosystems, facilitated by Academic Health Science Networks, to ensure patients and the public have timely access to transformative innovation."

This amendment would mandate Trusts to work with AHSNs to promote innovation in health services.

Innovation has allowed us to conquer certain diseases and come up with better and more effective treatments for others. It is integral to societal progress and is a major source of inspiration, new opportunities and, indeed, new financial burdens for the NHS. Most importantly, it means improved outcomes for patients. Innovation needs to reach patients if we are to get the full benefit of the many incredibly talented people who make up our academic and research community.

Academic health science networks have an informal role in the NHS, and there is no obligation on any CCG to work with them to ensure that new, innovative medicines are available. There are 15 academic health science networks across England, which were established by NHS England in 2013 to spread innovation at pace and scale, improving health and generating economic growth. Each network has a distinct geography, covering a specific population in each region—it almost sounds like an integrated care system, but there are not quite as many. They are the only bodies that connect to the NHS and the academic organisations, and are catalysts that create the right conditions to facilitate change across health and social care communities with a clear focus, as we believe should be the case, on improving outcomes for patients. We think they are uniquely placed to underline and spread innovation at pace and scale, driving the adoption and spread of innovative ideas and technologies across large populations, but their effectiveness rests on their ability to bring people, resources and organisations together quickly, delivering benefits that could not be achieved if they operated in isolation.

Everything those bodies do is driven by two imperatives: improving health and generating economic growth in our regions. They are the only partnership bodies that bring together all partners across a regional hub economy to improve the health of local communities. They have a remit from NHS England to occupy what is effectively a unique space outside the usual NHS service contracts and performance management structures, enabling them to collaborate to foster important solutions.

[Justin Madders]

Those bodies use local knowledge to harness the influence of partners to drive change and integrate research within health improvements. They are interested in seeing healthcare businesses thrive and grow, creating jobs, bringing investment and seeing the system improve. They have a different focus, but they share the following priorities: promoting economic growth; fostering opportunities for industry to work effectively with the NHS; diffusing innovation; creating the right environment; and supporting collaboration across boundaries to adopt and spread innovation at pace and scale. They improve patient safety by using knowledge, expertise and networks to bring together patients, healthcare staff and partners to determine priorities and to develop and implement solutions. They optimise medicine use—*[Interruption.]* Perhaps I have predicted what the Minister was about to say?

Edward Argar: I am envying the shadow Minister's breath control as he runs through his list.

Justin Madders: I am merely trying to ensure we make good progress today.

Those bodies ensure medication is used to maximum benefit, including safety and making efficient use of NHS resources. They improve quality and reduce variation by spreading best practice—we often talk about the variation among outcomes across different parts of the country. They put research into practice, collaborate on national programmes, and have a unified focus on various initiatives, including the NHS innovation accelerator and patient safety collaborative programme.

The amendment would bake in that good work, some of which I have outlined, by including those bodies within the scope of proposed new section 14Z39 of the National Health Service Act 2006 regarding innovation.

Karin Smyth: I rise to support my hon. Friend. We have rightly criticised much of what has happened in the last few years, but we should also remember that some amazing partnerships and networks have developed, including in my area—Bristol, north Somerset and south Gloucestershire—with the universities and others in both primary and secondary care, bringing together clinicians, researchers and so on. They stumbled initially as things were difficult at the beginning, but they have come together very well. They are well regarded—variable but well regarded—and are a useful source of innovation coming together, so I fully echo my hon. Friend's comments.

Edward Argar: I am grateful to the shadow Minister, the hon. Member for Ellesmere Port and Neston, for facilitating the debate on this matter, and, as I said, I admire his ability at pace and fluently to rattle through a long list of examples.

As the shadow minister said, the amendment relates to the role of ICBs and ICPs in relation to innovation. First, I want to reassure the Committee that I share his view on the vital importance of research to the NHS and the UK more widely. We are committed to being a research superpower and fully support research and innovation in the NHS and the public being given timely access to transformative medicines and treatments resulting from that innovation.

The example we would all use at the moment is vaccine development. That is a phenomenal example, and it is at the forefront of many of our minds. That is why we have replicated the research duty on CCGs for ICBs to continue a system that has been working well. We are fully supportive of research and ensuring that effective health, public health and social care services are delivered, but we cannot support the amendment.

3 pm

Amendment 58 would require integrated care boards to work with innovation and life-science ecosystems, facilitated by the Academic Health Science Networks. We welcome collaboration and co-operation but we do not think it is appropriate to focus solely on the Academic Health Science Networks as the facilitator of such collaboration and co-operation. The AHSN is a non-statutory entity, and although it is a valuable addition to the sector, a range of other bodies—including the National Institute of Health Research, through infrastructure such as the NIHR applied research collaborations, the clinical research network and UK Research and Innovation, not to mention the large numbers of research charities and other partners—could be relevant both now and in future. Applying the requirement in the amendment would risk giving ICBs an artificially narrowed focus and therefore potentially miss other opportunities.

Secondly, the existing duty does not specify how integrated care boards must act to promote innovation. It is right to allow for flexibility, which encompasses working with others but is not limited to doing so.

I hope that I have given the Committee some reassurance on the importance and value that we attach to research as a key part our health and care system, and also explained why we think it is right for ICBs to have a duty to promote research on relevant health service matters and to use evidence from such research, without our being over-prescriptive as to how they should do so. I hope that I have offered the shadow Minister, the hon. Member for Ellesmere Port and Neston, some reassurance and words of comfort.

Justin Madders: I am grateful for the Minister's comments. The Opposition would not want to be accused of being over-prescriptive—that is certainly not what we intend. I appreciate what the Minister said about not wanting to limit the role of ICBs and he made a good point about the vaccine roll-out being a pertinent example of how innovation can be of huge benefit. That may be at the forefront of his mind because there is now a vacancy in the Department in the role of Minister for Covid Vaccine Deployment; the Minister may be looking to add to his already extensive portfolio.

I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Chris Skidmore (Kingswood) (Con): I beg to move amendment 7, in clause 19, page 17, line 7, leave out from beginning to end of line 9 and insert—

"(a) support the conduct of research on matters relevant to the health and care system,

(b) work with universities and other research settings to support the development of the health research workforce and careers, and

(c) promote the use in the health and care system of evidence obtained from research."

This amendment would require Integrated Care Boards to work with universities to support research in their local health and care systems.

The Chair: With this it will be convenient to discuss amendment 8, in clause 19, page 17, line 13, after "1F(1)", insert "and work with universities and colleges".

This amendment would require Integrated Care Boards to work with universities and other education providers to promote education and training in their local health and care systems.

Chris Skidmore: The amendments would place a legal duty on integrated care boards to support and promote the use and development of research in their local health and care systems. The existing legislation talks about the health system; this is the Health and Care Bill, so it makes sense that the duty to promote research should also promote research in care settings.

Importantly, amendment 7 would promote and support the conduct of research alongside universities, which drive research outputs and innovation in healthcare. We would all agree that that has been highlighted throughout the pandemic: if it was not for our universities, we would not have all received a vaccine, in respect of which the United Kingdom has been at the forefront of research and innovation.

In the specific context of the Bill, it is important to require ICBs to engage with universities and other research settings on the development of the healthcare research workforce. ICBs will have a vital role in ensuring that we have sufficient numbers in not only the health workforce but the healthcare academic workforce, which is key to overall healthcare workforce sustainability. That is particularly important for the development of the clinical academic workforce. Clinical academics work in higher education institutions, conducting cutting-edge research and educating the future workforce while also providing clinical expertise to health and social care services. Because they remain clinically active, their research is grounded in clinical practice and questions that matter to services and patients.

Data from the Medical Schools Council staffing survey shows that although the total number of NHS medical consultants and GPs has risen by 40% over the past 15 years, the numbers of clinical academic have simply not kept up to pace—in fact, they have decreased, from 7.5% to 4.2% of the workforce. The proportion of clinical academic GPs has remained stable, but at just 0.4% of the GP workforce. Furthermore, less than 0.1% of the workforce in nursing, midwifery and the allied health professions are clinical academics. Increasing clinical academic capacity is essential to advancing evidence-informed practice and innovation in healthcare in the future. The point here is that expansion of the healthcare programme of student numbers on the UK Government's intended scale also requires an expansion of the number of healthcare academic staff.

The 2019 academic staffing centres of the Council of Deans of Health identify challenges for universities in recruiting staff and an ageing academic workforce in healthcare subjects. In England, 36% of academic staff are over the age of 50, and 9% are over the age of 60. That suggests that the academic workforce is significantly older than the healthcare workforce as a whole. It suggests that, within the next 15 years, almost half of the academic staff will be at or near retiring age, with many already likely to have retired. Without significant renewal of the academic healthcare workforce, not enough staff will be left to keep up with the number of students.

It is key that senior leaders in both the higher education and the healthcare sectors cultivate a culture of support for clinical academics. ICBs, health and social care providers and universities need to work in partnership to support clinical academics and clinical staff interested in secondments or joint appointments to universities. There should be opportunities for clinical staff to obtain experience and skills in teaching and also in research.

Amendment 7 ensures that ICBs remember their responsibilities to research, to local research priorities and to developing a local clinical academic research workforce, and universities are vitally involved in that important work. I think I am the only Member of this House who has been both a Health Minister and a Universities Minister twice. When I went into the Department of Health and Social Care, we were talking about integration between healthcare settings and social care settings. We have a similar problem with integration when it comes to looking at the medical workforce and ensuring that the education settings and the healthcare settings also integrate better together.

Amendment 8 returns to this point. It would require integrated health and care boards to work with universities to promote education and training in their local health and care systems. Universities are committed to co-creating healthcare services through working with practice partners, further education colleges and other stakeholders to plan and deliver the future workforce. I know that, when we come to clause 33, we will be talking about workforce planning at length, but this amendment would help to enable us to plan in advance to mitigate some of the problems that come with workforce planning for the future.

Universities are rooted in their local and regional communities and focus on improving healthcare outcomes and driving up economic and social wellbeing through providing programmes to meet skills gaps in those local areas. This is highlighted through the work of the universities during the pandemic, including the University of the West of England in my own locality hosting a Nightingale hospital, and the deployment of thousands of healthcare and medical students and some academic staff within clinical practice to expand the NHS workforce at the height of the pandemic. We all want to pay tribute to those medical students who, with no extra salary, gave up their time to volunteer to help staff on some of those covid wards at the time.

In England, universities currently sit on local workforce action boards and on sustainability and transformation partnerships to ensure that education is central to local healthcare planning. The amendment ensures that universities and colleges continue to be actively engaged by ICBs to plan and deliver on local workforce needs and priorities to ensure a sustainable workforce. This should take place alongside continued work with Health Education England.

Healthcare programmes are holistic and necessarily constituted of theory and practice components. For example, a registered nursing programme consists of 4,600 hours of education across three years—2,300 hours of academic learning and 2,300 hours of theory learning. Universities and their practice placement partners need

[Chris Skidmore]

to be involved in national and local workforce planning to ensure that there is adequate placement capacity in the system. As I saw when I was a Health Minister, placement capacity has long been recognised as a constraint to sector growth. Even if the hospitals wanted to expand, they did not have the placements to be able to deliver on the demand that was there.

ICBs must be involved in developing placement capacity and innovation and work with partners to increase placement opportunities outside the NHS, including in private healthcare, the third sector, social care, research and teaching, and international exchange. ICBs also need to work with education providers to think about developing education placements to support digital innovation and online and blended delivery, particularly considering the learning we have from the pandemic. That will help to support higher education institutions to manage the continued challenges posed by placement capacity problems, considering health service pressures.

Requiring ICBs to work with universities and colleges is also key to ensuring the success of healthcare apprenticeships and new technical qualifications such as T-levels. Universities work in close collaboration with local employers to develop and deliver healthcare apprenticeships. They are also committed to ensuring smooth articulation between further education and higher education, and universities are working with colleges to ensure that the healthcare T-levels and the new higher technical qualifications are rolled out successfully.

The amendment would ensure that the planning of future workforce numbers and sufficient placement capacity for all learner routes must be developed in partnership with education providers. That is crucial.

Alex Norris: I congratulate the right hon. Gentleman on his amendments and the case he made for them. I hope that he remembers with fondness his visit to the University of Nottingham and Nottingham Trent University when he was Universities Minister. He will have seen then the significant role that they play in our community, and I think they provide a good model for some of the things that we are talking about. I hope the Minister will address the points about clinical academics in particular. They were very well made, and I thought the right hon. Member for Kingswood also provided the basis for what will be a really interesting discussion on clause 33.

What attracts me to amendment 7 is that it is really important to send a signal to the leaders of integrated care boards that we want research to be central to their mission, as NHS Providers said in its evidence, and that we do not see them solely as administrators of health and care spending on a day-to-day basis, who every winter have to engage in collective crisis management to keep the lights on. We have much broader horizons in mind for them. If this is about new and enhanced models of more integrated care, we have to harness the expertise of academia. Hopefully, if this was effective and worked as a two-way process, with academics learning from inside the system and the systems learning from best practice from around the different footprints, that would be really powerful.

That relates neatly to the point about inequalities, from the beginning of our line-by-line consideration. The argument in favour of making that a priority was not about some sort of quixotic search for solutions or saying that something must be done, so let us just do something; rather, it is about taking evidence-based, high-quality interventions that work and putting them to work elsewhere. The sort of insights that amendment 7 proposes would certainly do that.

When I read amendment 8, my first instinct was, "I wish I had tabled it," because I think it is great. We want to foster a culture where we invest in and develop our people. That is true whatever someone's role is in the health and care service. Of course, that is really important in the NHS, and we all have a clear picture of what that looks like, but it is even more important in social care. We undervalue the role of social care in so many aspects, obviously and most tangibly in pay and conditions, but we also do not invest in people. Imagine how much more attractive a career in care would become if someone's training prospects went beyond the limited ones offered by whoever their employer happens to be and instead a wealth of other opportunities and courses backed by top higher education providers in their community was opened up.

My family's life was transformed by the impact that night school had on my mum's skills. She progressed from being an unqualified person working in childcare and turned that from a job into a career. That was completely transformative, not just for her life but for mine and my sister's. How terrific would that sort of picture be for people entering the care profession. It would be a wonderful thing. So there is a lot to go at here, and I am very interested in hearing the Minister's views on how we can try to foster that culture, if not through amendments 7 and 8.

Dr James Davies (Vale of Clwyd) (Con): I rise to speak in support of the agenda raised by my right hon. Friend the Member for Kingswood in his amendments 7 and 8 and the need for integrated care systems to ensure that NHS organisations for which they are responsible conduct and resource clinical research.

I think all would agree that the UK life sciences sector is world-leading. That was evidenced during the pandemic by the way in which early PCR testing was brought forward for covid, by the recovery trial and by vaccine development and so on. In this country, however, the location of existing activity is all too often limited. We have world-renowned centres of excellence, often associated with teaching hospitals. I would do nothing to weaken that. The Government's levelling-up agenda needs to extend involvement in such activity across the country. But at the same time, it can strengthen what Britain has to offer to patients and the world as a whole, bringing economic benefit to the country as well as to the NHS through increased income.

3.15 pm

Of course, I am a general practitioner. As a clinician, I would argue that research adds interest to the role. It can improve job satisfaction, reduce burnout and is of course a form of continuous professional development. That research element may make roles in more peripheral or less affluent parts of the country easier to recruit to. The amendment does not relate to Wales, but I know that Glan Clwyd Hospital in my constituency would benefit from closer research links with the teaching hospitals in Liverpool and Manchester.

Better patient outcomes can of course arise directly from involvement in trials and indirectly through a better functioning health system. I would argue that research needs mandating as it is otherwise all too often pushed to the back of the queue in a short-sighted attempt to maximise clinical output from staff. I would be grateful if the Minister considered that as the Bill proceeds.

Edward Argar: I am grateful to my right hon. Friend the Member for Kingswood for tabling his amendments and allowing us to have this debate. As has been mentioned, he was both my distinguished predecessor in this role and a very distinguished Minister for universities and research.

Amendments 7 and 8 relate to requiring ICBs to work together with higher education institutions and to their research duty. With the consent of the Committee, and with yours, Ms Elliott, I will start with amendment 8 and revert to amendment 7. Amendment 8 would alter the statutory duty placed on ICBs to promote education and training when exercising their functions to assist the Secretary of State and Health Education England in the discharge of their statutory duties. The Government believe that integrated care boards should promote education and training for people who are employed or considering becoming employed in the provision of NHS services, and that is what proposed new section 14Z41 of the National Health Service Act 2006, in clause 19, achieves that. This provision mirrors the duty currently imposed on clinical commissioning groups. In discharging the duty, ICBs will invariably work with higher education institutions as well as other educational providers as they consider appropriate.

At this point, the Department does not think that it necessary to mandate specific details of how ICBs should discharge that duty under proposed new section 14Z41, particularly as NHS England will have a power to issue guidance to ICBs on the discharge of their functions, which should serve to clarify the system. The draft guidance published by NHS England and NHS Improvement in August 2021 states that the delivery of ICBs' responsibilities will include working with educational institutions to develop the local future workforce across the health and care system. We believe that that guidance sends a strong signal to the system of the importance of the issue, reinforcing the statutory duty that ICBs will be under to promote education and training. Furthermore, it is worth noting in that context that ICBs will not be the only place in the system where engagement with higher education institutions will be taken forward.

HEE works extremely closely with higher education institutions and other education providers both nationally and through non-statutory regional people boards, jointly with NHS England, to ensure that the education and health systems are producing the right number of people with the right skills for our NHS. For example, Health Education England has already offered to support ICBs through the provision of workforce development support.

I will now turn to amendment 7, before wrapping both amendments together. I start by reassuring my right hon. Friend and other hon. Members who have spoken in this debate that the Government remain fully committed to supporting research as part of our NHS. Currently, clinical commissioning groups are under a duty to promote research; the Bill places the same duty on integrated care boards. That duty is discharged in a variety of ways—for example, with some CCGs having research strategies or research offices, providing details on how people can participate in research locally, or being partners in research organisations. Rather than being direct funders or directly conducting research themselves, the role of integrated care boards is to facilitate and enable research.

A duty to promote research gives greater flexibility for integrated care boards to determine how best and most effectively to engage with and encourage research in their local system. For example, NHS Liverpool CCG is the host organisation for the National Institute for Health Research Applied Research Collaboration North West Coast, while NHS Norfolk and Waveney CCG has a dedicated primary and community care research office, which works with a range of stakeholders, including academics, to develop and support the delivery of healthcare research across the area.

The amendment would modify the research duty on integrated care boards by replacing a requirement to promote research on relevant health service matters with one to "support the conduct" of that research. It also contains an additional requirement for ICBs to work with universities and other research settings to support the development of the health research workforce and careers.

We believe that there would be relatively little practical impact from changing the duty to one of supporting the conduct of research, and that there would be the potential to cause some confusion to staff moving from CCGs to ICBs as to what was expected of them. On the question of developing the health research workforce and careers by working with universities and other research settings, there is a risk in highlighting universities in particular, as that might imply an exclusion of other education facilities, although I know that that is not the intent. Furthermore, I have already highlighted the effectiveness of the proposed education and training duty, which includes the research workforce. Finally, the duty in relation to promoting the use of evidence and research is already part of the existing ICB duties.

I hope that, given those reassurances, my right hon. Friend the Member for Kingswood will not feel that he has to press his amendments to a vote. I look forward to continuing to speak with him as proceedings on the Bill continue, to ensure that when it becomes law, we end up with something that accurately reflects what we need in order to carry on being a powerhouse of innovation and research.

Chris Skidmore: I thank the Minister for his considered comments on these amendments. They are probing amendments, and I do not intend to press them to a vote. I hope, however, that the Department will consider not only the discussion that we have had in Committee today, but a letter that was sent to the Minister's office on 14 September from Universities UK, the Medical Schools Council and the Council of Deans of Health, which have all signalled their support for a form of words in an amendment that recognises the potential difficulties about placement planning and the opportunities represented by putting measures in the Bill about ICBs demonstrating integrated working.

I have been in Bill Committees before—I am now legislating to take out a lot of what I legislated for 10 years ago, when I was dealing with what became the

[Chris Skidmore]

Health and Social Care Act 2012. These Bills do not come around very often, so we have a fantastic opportunity, as the oral evidence sessions demonstrated, and I fully appreciate it. I have removed and re-tabled one of my amendments, to clause 33, as a result of the feedback from the oral evidence sessions.

There is a tension about how prescriptive we should be when the very culture of the Bill is about locally led practice and delivery and ensuring that we give health service managers and clinicians the opportunity to decide what is best for their local areas, so I do appreciate that prescription here may be unnecessary, but I felt it was important that I raised this as an opportunity to make a change in the Bill.

When it comes to clause stand part, I would like to speak more generally on clause 19 about the value of research, which my hon. Friend the Member for Vale of Clwyd has spoken about. I think we have an opportunity—it is one that I do not want to miss—when it comes to embedding research within the future of the NHS. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Alex Norris: I beg to move amendment 46, in clause 19, page 25, line 37, at end insert—

"14Z58A Power of the Domestic Abuse Commissioner to obtain information

(1) The Domestic Abuse Commissioner may require an integrated care board to provide the Domestic Abuse Commissioner with information.

(2) The information must be provided in such form, and at such time or within such period, as the Domestic Abuse Commissioner may require."

This amendment places a requirement on Integrated Care Boards to share information with the Domestic Abuse Commissioner at their request.

This is the first of a couple of amendments relating to domestic abuse. I hope it is not necessary, but it is my best avenue for establishing a point. I am really hoping for a one-word answer from the Minister—in my experience, a one-word answer is better than a two-word answer—and I hope that we can make quick progress with the amendment.

In England and Wales, the Domestic Abuse Act 2021 created the post of Domestic Abuse Commissioner, who is in the vanguard of holding to account authorities and agencies to ensure that their process and plans promote our national attempts to tackle domestic abuse. Currently, the post is filled by the excellent Nicole Jacobs. She has the power to obtain information from public bodies such as the local police, the local council and the Care Quality Commission, so that she can express her views as to whether those organisations are acting in line with well-evidenced best practice in the decisions that they take. That is an important way in which we can be assured that public policy decisions on the ground from day to day reflect the national consensus on what we are trying to achieve.

Currently, NHS bodies are in scope of the commissioner's powers, and I want to clarify that ICBs and any relevant sub-committee would also be in scope. The composition of the boards will not matter, and there will be no shielding behind commercial confidentiality. The body will sit consistently with other, similar bodies, and the commissioner will be able to get the information she needs to do the job that we have asked of her.

Edward Argar: I am grateful to the hon. Gentleman, and I share his view that it is crucial that integrated care boards co-operate with the Domestic Abuse Commissioner. I think I speak for the whole Committee when I say that we agree that the health and social care system has a crucial role in preventing and tackling domestic abuse, and in supporting victims who experience this horrendous crime. Indeed, before the last reshuffle, when I moved from Justice to Health, I was one of the Ministers working with the Under-Secretary of State for the Home Department, my hon. Friend the Member for Louth and Horncastle (Victoria Atkins), on the genesis of what is now the Domestic Abuse Act. Therefore, we wholeheartedly welcome the introduction of the Domestic Abuse Commissioner's role in the Act.

The commissioner has a vital role to play in monitoring the response to domestic abuse, sharing best practice and challenging bodies, including in health and social care, to go further and to do more. The commissioner will require information, support and co-operation from integrated care boards as well as a range of other public bodies. That is why the Domestic Abuse Act contains a duty to co-operate with the Domestic Abuse Commissioner, and we have made it clear that that will apply to integrated care boards and their component parts. It will also apply to requests for information from the commissioner. That is a little more than one word, but I hope I have reassured the hon. Member for Nottingham North that there is already such provision, as there should be. I hope that he will feel able to withdraw his amendment.

More broadly, the Department for Health and Social Care will be taking steps to ensure that integrated care boards also have the right guidance and support to ensure that they fulfil their duties in relation to domestic abuse, as well as violence against women and girls, and sexual violence more broadly. We will be following the Government's recent violence against women and girls strategy by engaging with current ICSs, the wider sector and the commissioner, so that we identify best practice and share that guidance across the system to ensure that all parts of the system play their part.

Alex Norris: I am grateful for that answer and clarification. On that basis, 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: This clause inserts 31 new sections into the NHS Act 2006. It is the cornerstone of the integrated care board provisions, as it sets out the functions and duties that ICBs are required by legislation to fulfil. Clause 19 contains a number of provisions and duties in respect of ICBs. Given the importance of these provisions in the Bill, I will take Members through them, if they will forgive me, in a little detail.

3.30 pm

Proposed new sections 14Z32 to 14Z42 set out a number of different duties that apply to ICBs. These include to act in line with the NHS constitution and promote awareness of the NHS constitution; to exercise functions effectively, efficiently and economically; to

act to continuously improve the quality of services; to seek to reduce inequalities in health outcomes and access to health services; to promote the involvement of patients and their carers and representatives in decision making about their care; to enable patients to make choices concerning the health services provided to them; to obtain expert professional and clinical advice for decision making; to promote innovation in the provision of health services; to promote research on matters relevant to the health service and the use of evidence obtained from research; to promote education and training; and to act to secure integration of health services, and between health services and social care services, where this would improve the quality of services or reduce inequalities in access to care or outcomes.

Proposed new section 14Z43 sets out the triple aim duty for ICBs in the same way as other clauses in the Bill have provided for that in relation to other bodies. This means that when making decisions, ICBs must consider the impact of decisions on the health, including mental health, and wellbeing of the people of England; the impact on the quality of services provided or arranged by NHS organisations, including NHS England itself; and the sustainable use of NHS resources. In addition, other existing duties placed on CCGs are recreated in this clause so that they will now apply to ICBs.

Proposed new section 14Z44 sets out requirements for involving the public, including carers and their representatives, whether by consultation or otherwise, when an ICB is exercising its functions. This will ensure that the voice of residents, those who access care and support, and carers is properly embedded throughout the health and care system, and that we have a health and care system that is accountable and responsive to the people who use it.

Proposed new section 14Z45 provides that regulations may be made to allow any prescribed function of an ICB to be exercised jointly with a local health board. Local health boards commission and provide health services in Wales, so this provision will continue to assist the smooth commissioning and provision of cross-border health services. I look at my hon. Friend the Member for Vale of Clwyd as I say that, as I know it will be of interest to him.

Proposed new section 14Z46 allows ICBs to raise additional income for improving the health service, provided this does not significantly interfere with the ICB's ability to perform its functions. ICBs are allowed to make grants or loans to NHS trusts, foundation trusts or voluntary organisations in certain circumstances under proposed new section 14Z47.

Proposed new section 14Z48 gives NHS England the power to publish a document specifying the circumstances in which an ICB is liable to make payments to a provider to pay for services provided under arrangements commissioned by another ICB. This provision could, for instance, enable NHS England to specify that where a person uses an urgent care service commissioned by an integrated care board other than the integrated care board ordinarily responsible for that person's healthcare, the cost of that service is charged to the latter integrated care board. Proposed new section 14Z49 places a requirement on NHS England to publish guidance for ICBs on the discharge of their functions, which ICBs must have regard to.

This clause also inserts proposed new section 14Z50, which requires each ICB, alongside its partner NHS trusts and foundation trusts, to prepare a joint plan setting out how it will exercise its functions over the next five years. This plan must, in particular, detail how the ICB plans to continuously improve services, reduce health inequalities, take into account the wider effects of decisions, involve and consult the public in decision making, meet its financial duties and implement any relevant joint local health and wellbeing strategies.

The plan may be revised as provided for under proposed new section 14Z51. By requiring ICBs to undertake long-term planning, we will ensure that a long-term strategic approach is taken to commissioning. ICBs are required to publish plans and send them to NHS England, the relevant integrated care partnership and any relevant health and wellbeing boards. They are also required to consult widely when developing forward plans, including on whether the plan adequately reflects health and wellbeing strategies.

Proposed new section 14Z52 sets out consultation requirements, and proposed new section 14Z53 explains how health and wellbeing boards can provide their opinions in relation to the forward plans. These provisions will ensure that ICBs are accountable and responsive to the people who use the health system, and that they take into account local needs and priorities when developing commissioning plans.

Under proposed new section 14Z54, before the start of each financial year an ICB and its partner NHS trusts and foundation trusts must prepare a plan setting out their planned capital resource use in relation to the period that the Secretary of State directs. NHS England may give directions as to which capital resources need to be taken into account in the plan. Proposed new section 14Z55 allows for that plan to be revised and sets out how it must be published and shared transparently.

Under proposed new sections 14Z56 to 14Z59, at the end of each financial year ICBs must report to NHS England on how they have discharged their functions, and NHS England must undertake and publish a performance assessment of ICBs. NHS England may require an ICB to provide NHS England with any necessary documents or other information. Where an ICB is deemed to be failing to discharge a function or at risk of doing so, NHS England will have powers to intervene. This will ensure that there are strong lines of accountability from ICBs through NHS England to Parliament, as well as public transparency.

Finally, proposed new section 14Z60 provides that ICBs are permitted to disclose information obtained in the exercise of their functions if it meets the lawful requirements, and proposed new section 14Z61 defines the terms used in this new chapter inserted into the National Health Service Act 2006.

Thank you for your forbearance, Ms Elliott, but I am sure you will agree that this clause covers a lot of key elements, and it is essential for setting out the core functions of ICBs and placing statutory duties on ICBs to deliver our priorities of reducing health inequalities and promoting integration with health and social care services. Moreover, the clause establishes clear lines of accountability and commitments to transparency that are essential for ensuring that ICBs are adequately held to account. I commend the clause to the Committee.

Justin Madders: I am grateful to the Minister for that herculean effort in listing all the powers and responsibilities of ICBs. For a permissive Bill, the fact that it sets out 12 duties suggests that the pendulum has swung a little bit further than the Minister was perhaps prepared to admit on Tuesday. Of course, the number would have been even higher had our amendment been accepted, but there we go; a dozen is still an impressive amount. However, it is really about what that means in practice.

The Minister referred to the duty whereby ICBs are required to promote awareness of the NHS constitution. In the context of the debate that we have just had on NHS waiting lists, it strikes me as similar to the scene—it might be familiar to many Members—at the end of each "Bullseye" episode, when the speedboat that the unlucky contestant had not succeeded in getting was brought out, so as to say, "Look what you could have won!" In this case, it is, "Look what the NHS constitution says about waiting times. By the way, we are not delivering on that for you." That is the nub of some of the duties—how will they be enforced in practice? The Minister referred to mechanisms for NHS England intervention, although we would have liked that to be further strengthened with specific reference to waiting lists.

I note that in proposed new section 14Z59(4), NHS England has retained the ability to terminate the appointment of an ICB chief executive, but also to direct the chair of the board as to which individual to appoint as their replacement and on what terms. That is quite a strong power. The way I read that, if NHS England decides to get rid of someone, it, and it alone, will decide who will replace them. That really goes against the spirit of what we have been discussing for the last couple of days. Would the Minister be able to allay my fears in that respect, or at least put into context the circumstances in which that clause might operate?

I was interested to hear what the Minister said about proposed new section 14Z47 and ICBs' ability to offer grants and loans on whatever terms they see fit. It now seems that the "B" in ICB stands for bank, or possibly building society. Obviously, at the moment these bodies do not exist in law and so have no capital resources to draw on to create such grants or loans, but of course that will change in due course. Again, will the Minister advise the Committee in what kind of situations that might be a possibility?

Finally, I draw the Committee's attention to the powers and responsibilities in proposed new section 14Z52, on health and wellbeing boards' comments about forward plans. Like much of this, it is a process-driven, tick-box exercise where people have to "take regard" and explain why they are not doing something that everyone else has asked them to do. A whole lot of this raises the question: in a disagreement, what are the levers to get proper accountability and change that the whole of the system, apart from the ICB, wants to see?

Chris Skidmore: Although I entirely support clause 19 as an essential ingredient of the Bill that will provide certainty and legal confidence to ICBs, I wish to draw the Minister's attention again to the duty to promote research. The past year has demonstrated the increased engagement, across all healthcare settings, in research and those activities relating to the pandemic.

Research demonstrates the enormous benefits not only to patients, but to organisations that see improved outcomes, lower mortality rates and increased confidence in care as a result of being research-led organisations. It also shows the staggering gross value added that is produced within the NHS—£2.7 billion in 2018-19, through the National Institute for Health Research clinical research network that supports clinical research activities. For every patient recruited on to a commercial trial between 2016 and 2018, the NHS in England received more than £9,000. When a drug is replaced by a new one—a trial drug—there is another saving of nearly £6,000.

Research not only improves lives; we know it saves lives. I am a passionate advocate for expanding our research and development capacity across society if we are to succeed as global Britain. That is one reason we have that cross-Government target of raising the amount spent on R&D, both public and private, to 2.4% of GDP by 2027.

I want to come back to this idea of the duty to promote research. I recall serving on the Bill Committee for what became the Health and Social Care Act 2012, when the duty to promote research was first written into legislation, with the duty on CCGs. That has now been transferred across in the text for ICBs, in proposed new sections 14Z39 and 14Z40 to the National Health Service Act 2006.

As my hon. Friend the Member for Vale of Clwyd mentioned, the duty to promote may not be strong enough. I do not have an amendment to hand, but I wanted to raise this point more generally so that the Minister and his Bill team might give it some consideration. Given that ICSs are established as the strategic system leaders for the NHS and partner organisations to deliver integrated care and take that whole-systems approach, research will have to be a core element of ICSs' regional plans if we are to maximise the strengths of the NHS, our world-leading science capability and the opportunities I have spoken about.

I therefore urge the Government to consider whether there might be an opportunity to change the duty to promote into a duty to conduct and resource clinical research during the passage of the Bill. It is important to stress that a duty to promote has to be accompanied by the necessary infrastructure: staffing levels, research capability, digital resources, access to services, efficient trial approval processes, the ability to reliably recruit patients, guidance and dedicated staff time for research. The whole idea of "promotion" is doing a lot of heavy lifting. There might be an opportunity for us to be more detailed in creating a duty to conduct and resource clinical research.

Such a duty—this has been raised with me—would present the opportunity that research brings to highlight clinical inequalities within the NHS. We need to be able to measure research activity; we cannot manage or even promote research activity unless we are able to measure it effectively. With that comes the whole question of clinical auditing—making sure that there is an effective auditing process in place to ensure that research-led activities are able to be effectively measured and therefore effectively managed. I am sure that that will be raised in the other place during the passage of the Bill. I act as a canary in the coalmine to provide the Minister with due warning that I am sure these debates will come up during the passage of the Bill in the other place.

3.45 pm

Hywel Williams (Arfon) (PC): It is a pleasure to serve under your chairmanship, Ms Elliott.

I have some questions for the Minister about the cross-border joint committees. I would, of course, be happy if he could answer them this afternoon, but he if wishes to have a period of further consideration I would be content for him to write to the Committee with the answers.

Clause 19 sets down the prescribed functions of an integrated care board that can be exercised jointly with the local health board in Wales. This is to be the responsibility of joint committees. The clause replaces the regulations in the National Health Service Act 2006, which provide that any prescribed functions of a clinical commissioning group can be exercised jointly with local health boards. The immediate questions for me are quite obvious—the who, what, why and how sort of questions—and I have not seen any details on this matter as yet, although I might have missed something.

As to my questions to the Minister, first, the why is quite clear: people from Wales access specialist services in England, as I am sure the hon. Member for Vale of Clwyd would point out if I did not. People from border areas, but also from the far north-west of Wales where I live, access services in Manchester and are very glad to do so. Indeed, people from England access services in Wales as well, although that is less remarked on. Cross-border traffic is usually couched in terms of dependency from Wales, but it might interest the Committee to know that in 2019, 13,500 people from Wales accessed GP services in England, while at the same time, 21,000 people from England accessed GP services in Wales. That might, of course, be something to do with the free prescriptions provided by the Labour Government in Wales—I could not possibly comment.

To be clear, as a Plaid Cymru Member and a nationalist, I think co-operation is not just desirable but essential to ensure that fair and effective cross-border arrangements are in place. There will, no doubt, be opportunities to compare and contrast and to learn from each other. As I said, however, I would like the Minister to address some of my questions. This is not an exhaustive list.

First, to what degree have the Welsh Government played a part in drawing up the arrangements for joint committees? I am sure there have been discussions. For example, how will the membership of joint committees be decided? There has been a good deal of concern in debates in this Committee about private providers having seats on ICBs, as we have already heard. Pertinently to this matter, the private sector has a lesser role in the provision of health and social care in Wales. We are not talking about identical services here. The private sector might have a greater prominence on the other side of the border. Has it been agreed with the Welsh Government that private providers are to have seats on joint committees or not? If so, what safeguards will be in place to prevent the conflicts of interest that were referred to on Tuesday?

What structures will be in place to ensure that there is national Welsh consistency in decision making between the joint committees along the border? Will there be a national framework, although perhaps that is the responsibility of the Welsh Government rather than the Government here in Westminster, for coming to agreements on the delivery of services, or will it be up to the local joint committees, with the danger of a postcode lottery? As I said, I think this might be a matter for the Welsh Government rather than the Government here in Westminster. It has been agreed, I hope, so I would like to know what was agreed.

Lastly, in respect of the detailed points, to whom will the joint committees be accountable: to their respective ICBs or health boards, to the Government, or to the ICB on one side and the Welsh Government on the other? How will that be done? Indeed, when consultation—wide consultation, I hope—is undertaken, will it happen across the border as well? Will Welsh patients be able to have their say? There are more questions that I will pursue, and more will surely arise as the joint committees begin their work. I hope the Minister appreciates that these matters need further explanation.

Finally, I have three broader points. Perhaps the Minister can clarify whether there have been discussions on these points and what has been decided about the services provided over the border. First, I am worried about divergence in health policy between Wales and England. There is a wellbeing approach to health in Wales, as I said in the debates on Tuesday. Might any difficulties arise from that? There might be some difference between what is available in Wales and what is available over the border.

Secondly—this is a particularly important matter where I live—has there been any discussion on whether services provided from England into Wales are consistent with the Welsh language requirements of the Welsh health service? I think there is a problem here, and some services provided into Wales from England are really aware of this. I think of the Robert Jones and Agnes Hunt Orthopaedic Hospital in Gobowen, which has Welsh-language services for people coming in from Wales. The hospital is just outside Oswestry, not far from the border. That is an issue to be examined, and perhaps to be answered by the Minister today or in a letter.

Lastly—this is more of a point in law, or possibly a philosophical point—can ICBs, which are ultimately the responsibility of the Government here in Westminster, be accountable to the Welsh Government, who have their power devolved from London? To put it more directly, can the Welsh Government peck up the pecking order towards bodies over in England? That has been a real question for services provided from outside Wales by Government bodies or agencies. Over many years, there has been quite a debate about bilingualism in the services provided into Wales by the Department for Work and Pensions. Again, that might not be a problem, but I would be grateful for the Minister's views on this issue and on the other questions that I have raised.

Edward Argar: I am grateful, as ever, to my right hon. Friend the Member for Kingswood for his comments. I hope I can reassure him that the issues he raised, and the issues that he has aired in the Committee today, will continue to be reflected on carefully by officials and Ministers during the passage of the Bill.

I will try to address the specific points raised by the hon. Members for Ellesmere Port and Neston and for Arfon. The hon. Member for Ellesmere Port and Neston touched on the appointment of chief executives and the termination of appointments. That power is broadly

[Edward Argar]

akin to the current power that CCGs have, and we are simply moving across the power that NHS England has over CCGs to reflect the new environment of integrated care boards.

Justin Madders: I am grateful for the clarification from the Minister, but does that not expose our fear that, really, ICBs are just bigger CCGs?

Edward Argar: No, because at the heart of ICBs is an enhanced integration and partnership-working model, which will be a significant step forward to facilitate improved patient care in our constituencies and localities.

The power to make loans is analogous to the power that exists for CCGs.

The hon. Member for Ellesmere Port and Neston touched on forward plans and health and wellbeing boards. The ICB will have an obligation to consult the health and wellbeing board, including in respect of whether it takes into account the latest joint health and wellbeing strategy and provides the HWB with a copy of its plan.

On Wales, I fear that I may have to write to the hon. Member for Arfon with some of the answers, but I shall try to give some now so that he has at least something today. We are seeking not to make a policy change or anything like that but to carry the existing situation for CCGs across into the new arrangement. We have been consulting and working closely with the Welsh Government. I suspect that, as we heard from the witnesses, some in the Welsh Government may suggest that we should consult more closely, while others will say the consultation is adequate. I believe I have a good relationship with the Health Minister in the Welsh Government—I spoke to her only yesterday about a number of aspects of the Bill—and at official level conversations are constantly ongoing.

The hon. Member for Arfon touched on joint committees, which will involve ICBs and their Welsh equivalents. We would not expect private providers to serve on them because they will in effect exercise an ICB function. On Tuesday, I made it clear to the Committee that it is not our intention that private providers should serve on ICBs, so they should not serve on joint committees either. We will have further discussions with the Opposition Front-Bench team and others as to whether we can find a way to make that clearer in the legislation.

Finally, accountability remains essentially unchanged. The NHS in Wales is accountable to the Welsh Government and ICBs will be accountable to NHS England and, therefore, to the Secretary of State. The hon. Member for Arfon touched on the challenge of divergence or disparity of provision. I suspect that, in a sense, it comes baked into a devolution settlement that when power is devolved down there is sometimes a divergence of approach or there are different services. That is in the nature of any devolution settlement where specific services or functions are devolved. For example, as we have seen in our exiting from coronavirus regulations, the devolved Administrations have the right, under the settlement, to pursue the approach that they deem to be most effective.

I hope that I have addressed a number of the points made by the hon. Member for Arfon. I see my officials frantically scribbling down his other questions; we will endeavour to check *Hansard* and write to him with anything we have missed.

I commend the clause to the Committee.

Question put and agreed to.

Clause 19 accordingly ordered to stand part of the Bill.

Clause 20

Integrated care partnerships and strategies

Dr James Davies: I beg to move amendment 55, in clause 20, page 29, line 7, at end insert—

"(2A) When appointing members to the integrated care partnership, the integrated care partnership must pay particular attention to the range of services used by children and young people aged 0-25."

This amendment would require integrated care partnerships to consider representation from the full spectrum of services used by babies, children and young people, including education settings.

The Chair: With this it will be convenient to discuss amendment 54, in clause 20, page 29, line 32, at end insert—

"(c) include specific consideration of how it will meet the needs of children and young people aged 0-25."

This amendment would require an integrated care partnership to specifically consider the needs of babies, children and young people when developing its strategy.

Dr Davies: I move the amendment on behalf of my hon. Friend the Member for Eddisbury.

These probing amendments would require integrated care partnerships to involve in their joint committee the key partners—including schools and colleges—responsible for meeting the needs of babies, children and young people. The intention is to understand how we can best ensure that children's needs are given equal priority at ICS level. The Bill provides a genuine opportunity to reduce child health inequalities and improve children's health outcomes, which is all the more pressing following many children's severe adverse experiences over the past 18 months.

The Government's drive towards integrated services and greater collaboration, both within and beyond the health and care system, is very much to be welcomed, but if ICSs are to achieve their aims of improving population health and reducing inequalities, they must give equal weight to the needs of children when they plan and commission services. Why? Because children are a distinct population with their own workforce, infrastructure, developmental needs and legislation. Children's health is affected by a complex ecosystem of factors, with many interrelated systems encircling the child. Their health is determined not only by primary and secondary health services, but by their nursery or school, children's social care teams, the local authority SEND workforce, school nursing, health visitors and many other partners.

4 pm

Building integrated care systems, with babies, children and young people firmly in mind, has the potential to improve health outcomes for children across the country, including those with complex health needs and disabilities. That, in turn, can have a profound impact on population health now and long into the future.

If the key professionals and people involved in children's lives are missing from the discussions, there is a real risk that the needs of children and young people will not

receive the attention that they require. That is why every integrated care partnership should have a plan for involving the full spectrum of services used by children and young people aged zero to 25 and to provide clear leadership for children in an integrated care strategy. To that end, it is clearly also important that ICSs should consider how the voices of children, young people, and parents and carers will be represented in governance structures, including the voices of disabled children and very young children.

On amendment 54, the Bill as drafted will require every integrated care partnership to develop an integrated care strategy. Given that children have distinct health needs and experiences and use a distinct health and care system, it is vital that ICSs are required to consider how they will meet the needs of children when developing this pivotal strategy. When legislation does not explicitly require health systems to consider children, they are often forgotten about in policies and subsequent implementation. Analysis by YoungMinds found that a majority, or 77%, of sustainability and transformation partnerships failed sufficiently to consider children's needs. We cannot afford for that to be replicated in ICS structures.

If the Government are to deliver on their commendable vision to improve health outcomes and reduce inequalities across the whole population, and not just for adults, ICSs should be required to consider babies, children and young people when developing strategies that will determine the planning, commissioning and delivery of all health services. Some of the things that a strategy might consider include: where local leadership and responsibility for children sit; how the full spectrum of services accessed by children aged zero to 25 are represented in an ICS; the voices of children, young people and their families, including disabled children and very young children; and the capacity and skillset of the local children's workforce.

It is also important that every partnership recognises that children are not a homogenous group and have distinct needs at different ages. Strategies should also take into account the needs of children across the age range. Above all, it is crucial that there is a clear vision for children's health in every integrated care partnership to ensure that children are prioritised and not forgotten about during the move to statutory ICSs.

Alex Norris: I am grateful to the hon. Member for Eddisbury for tabling the amendments and to the hon. Member for Vale of Clwyd for stepping in to give the Committee a chance to discuss them. I agree completely with what he said about the Bill being a real opportunity on child health in this country and I hope that we can take it.

We should be saddened by what Barnardo's said in its written evidence:

"Children growing up in England…face some of the worst health outcomes in Europe"—

particularly those growing up in poverty. That is really saddening, not least because even prior to the pandemic, according to Action for Children, over 4 million children were living in poverty, including a staggering, breathtakingly sad 46% of children in black and minority ethnic groups. We must seek to do better. These things should stop us in our tracks, given the wealth that we as a country have, the technologies we have, the schooling we have and the assets we have, yet we cannot give our young people, particularly the poorest children, the best start in life. That is really sad.

The only enhancement that I would make to the amendments is that, rather than making them about ages nought to 25, I would extend the range to include the six months prior to birth, because we know how important those services are. I hope, in that spirit, that we may hear some enthusiasm from the Minister and his Government about implementing all the recommendations of the Leadsom review. I know that it will be hard, because it will involve acknowledging some dreadful decisions over the past decade, such as the reduction in Sure Start but, nevertheless, that report has real potential to be the bedrock for a return to something much closer to proper early intervention in this country. We might not have the saddening and completely avoidable outcomes that we have, so I hope that we hear some good news from the Minister on that.

Edward Argar: I am grateful to my hon. Friend the Member—I cannot pronounce that—and to my hon. Friend the Member for Eddisbury, on whose behalf my hon. Friend for Vale of Clwyd spoke. I also wish to put on the record my gratitude to Lord Farmer and his team for the work that they have been doing in this space. I have had the pleasure of meeting them, and—to reassure the shadow Minister—I have already met once, or possibly twice, with my right hon. Friend the Member for South Northamptonshire (Dame Andrea Leadsom) to discuss her review. I know that my hon. Friend the Member for Bury St Edmunds has also worked with her on it, and we continue to work together to try to find ways to move that forward.

I hope that all Members agree that the creation of integrated care boards and ICPs represents a significant opportunity to support and improve the planning and provision of services to make sure that they are more joined up and better meet the needs of infants, children and young people. We acknowledge that these amendments understandably intend to ensure that the needs of children and young people aged 0 to 25 are represented on the ICP and are considered by the ICP when developing its strategy. While we entirely agree with the intentions behind the amendments, we come back to the point that we wish to provide local areas with the flexibility to determine what will work best for their systems, their priorities and how they develop their plans and membership. Overly prescriptive approaches in the Bill would risk making it harder for systems to design the approaches that will work best in their area.

Turning to amendment 54, we would not want ICPs to create plans for children disconnected from the wider healthcare system. We know that the very best systems consider how their health systems are meeting everyone's need, including where there are transitions between different stages of life. However, I do hope that I can provide some further comfort for my hon. Friend the Member for Vale of Clwyd. We are working on bespoke guidance for babies, children and young people, which will set out clearly how ICBs and ICPs are obliged to deliver for them. This will cover the importance of the ICB forward plan and the ICP strategy and how they can set clear objectives for babies, children and young people. The Department is working closely on the drafting of this guidance with NHS England, the Department

[Edward Argar]

for Education and, indeed the relevant Minister, my hon. Friend the Member for Chelmsford (Vicky Ford)—I presume that she is still the relevant Minister as we speak. We will also be working with all stakeholders, including the National Children's Bureau, in the coming months. I suspect that this is a theme and an issue that we will return to at various points both in Committee and indeed in the further passage of this legislation.

I hope that I can reassure my hon. Friend the Member for Vale of Clwyd on this matter. I entirely understand where he is coming from, but ask that, on this occasion, he does not press his amendment—or the amendment of my hon. Friend the Member for Eddisbury—to a vote.

Dr Davies: I thank the Minister for that response. I know that my hon. Friend the Member for Eddisbury is particularly keen that these matters are covered within statutory guidance, but, with the leave of the Committee, I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Justin Madders: I beg to move amendment 47, in clause 20, page 31, line 31, at end insert—

"(3) The Secretary of State must make regulations which set out the procedure to be followed should an integrated care partnership believe that an integrated care board has failed in its duty under this section."

This amendment would require the Secretary of State to establish a procedure for the resolution of any dispute between an integrated care partnership and an integrated care board concerning the implementation of a strategy produced by the integrated care partnership.

The Chair: With this it will be convenient to discuss amendment 83, in clause 20, page 31, line 31, at end insert—

"(3) Where—

(a) in exercising its functions a responsible local authority or integrated care board diverges from an assessment or strategy mentioned in subsection (1), or

(b) in exercising any functions in arranging for the provision of health services in relation to the area of a responsible local authority NHS England diverges from an assessment or strategy mentioned in subsection (2),

that local authority, that integrated care board or (as the case may be) NHS England must—

(a) (i) within 30 days, make a public statement of its divergence from the assessment or strategy, and

(ii) within 60 days, publish its reasons for the divergence, together with any supporting evidence."

Justin Madders: I will talk briefly about amendment 83 which has been grouped with amendment 47.

Amendment 47 focuses on the whole discussion that we have had, and that we will continue to have, around integrated partnerships and what they will be able to do to deliver for their communities. I do not know if "Marmotisation" is a word; if it is, this could be seen as the first step towards that, but we will see how it works in practice. We must be clear, however, that this is a first step. The names of the partners being bandied about shows that this Bill is about the integration of not just health and social care but the whole wider public sector and other partners, and shows, too, that health issues permeate almost every walk of life. This certainly does not, as evidenced by the Prime Minister's comments last week, constitute a solution to the integration of health and social care.

Putting that aside, there is an opportunity here to do something different. However, for all the froth and grand statements about partnership working we fear we may be looking at giant CCGs with less GP involvement—we have made this point a number of times so I will not labour it. What we are presented with is a reorganisation of the NHS, not a panacea for integration. We have tried a couple of times already to elicit from the Minister what is missing from the Bill in terms of the integration that the Prime Minister believes necessitates a White Paper. I think the Minister might struggle sometimes to understand what exactly is going on in the Prime Minister's head in relation to this—or indeed anything else that is going on in his head—but we await his response on that with interest.

I would like to make some general points on the relationship between the NHS and local authorities, because that is important. The Bill acknowledges that greater interaction is needed, but the big question is whether it actually delivers that solution. If there is to be a genuine generational shift from thinking of the NHS as dealing with sickness to contributing to overall wellbeing, that will be welcome, although if our amendment on patient outcomes had been accepted that would have been a better start. There have been some discussions around SDPs and ICSs in the Bill, and that gives us hope that there might be something here we can work with.

The need to bring services together and integrate is blindingly obvious, but it is also very hard to do as the following example demonstrates. A patient with a long-term condition such as chronic obstructive pulmonary disease, and with both healthcare and social care needs, has an acute episode and is admitted to hospital and is then discharged back into their home, which unfortunately suffers from a chronic damp problem—something many Members will know about from their constituency casework. The housing provider—a local authority, perhaps, or an arm's length management organisation or registered social landlord—is doing its best, but it does not have enough resources to get to the root of the problem, so there is a liaison meeting where this case is discussed between the NHS and local councillors. The councillor for the area where the individual is located asks the chief executive of the trust whether it would be a good idea for some of the health budget to be invested in social housing so that people such as this individual would not be readmitted for a problem that is essentially caused by the property they are living in. The chief executive responds by asking why they would throw money away on something like that, even though a more holistic view shows that would be of benefit for everyone in the long run.

That illustrates why we need to work harder on integration, and it is not an isolated incident. As any councillor who has been in post for any number of years will know—if the Minister and I totted up between us how many years we have served, it would probably be quite a lot—sometimes it is difficult to have the level of interaction with the NHS that we would like. As an aside, I might add that children in care meetings or care

around the child meetings are incredibly important, but often the GP does not attend because they have many other priorities.

We have talked about this many times, but the vaccine roll-out has been an exemplar of how local government and the NHS can work together. That was a specific task at the time of the national crisis. It is clearly more difficult to repeat that kind of synergy on a day-to-day basis, but it does show what can be done.

In Wales, the Government have a far-reaching strategy around the wellbeing of future generations. They have made a big leap, moving the NHS away from market thinking and focusing on the way it delivers its service to the public. Both Scotland and Wales have accepted the need for that approach, and their integrated joint boards, joint integration boards, health boards and local authorities have all been talking about integration for some time. Of course, they have the sense to make their health boards coterminous with local authority areas. That would have been a very wise move. We have already had some chat about devolved involvement and I am sure that we will return to that.

4.15 pm

The Bill at least makes a start on how we move away from the market and talk more about collaboration, but it fails to challenge the dominance of the big acute trusts, which have their own priorities and often take the lion's share of resources. Thirty years of experience with commissioning with CCGs and primary care trusts shows that it is difficult to challenge and influence these larger provider trusts, so how will the combination of ICBs and ICPs be any different?

I have described things in this way, because at the heart of the issue that we are trying to address with the amendment is how the money is spent: who sets the priorities and allocates funding, down to the place or the particular service? If it is just the NHS, the same problems will still apply; it is not going to change anything in reality. Somehow we have to broaden decision making and accountability to ensure that all voices are heard. As we said earlier this week, that has to include the public and patients. If our amendments in that regard had been accepted, we might have made a start on that. We have heard many times that the ICB is an NHS body that it is accountable for NHS money and that the ICP has no role in resource allocation, and we know that money often dictates influence and power.

We have had health and wellbeing boards for years. They have had a similar role to the ICBs, setting out a wider strategy. However, it is fair to say that they do not always have the influence they would like. They were, in effect, an afterthought to the machinations of the Health and Social Care Act 2012. I wonder whether the Minister is aware of any assessments or studies on the effectiveness of health and wellbeing boards, particularly on whether they have produced a shift in policy at a system level.

It is worth reminding the Committee—we touched on this on Tuesday—that the National Health Service Act 1946 was set up with local authorities very much at its heart. The NHS and local authorities worked together closely, but as time has gone on that divide has grown. We need to think about devolution and the direction of travel more generally. There is more that we can do in that respect. We support the prospect of more devolution, but that has to be more than a simple passporting of funds down through a body to another provider. Our amendment is about giving real power and influence to local communities, making devolution mean something and taking back control, not the passing of powers from one set of unelected people to another.

I have dealt with some of the philosophy, so let me now turn to the practicalities. Many have said in response to the Bill that they want minimal prescription. We understand that, which is why we are trying to do this with one single clause. Much is left to local bodies to try to sort this all out together, and many will be able to do that, but we know that that will not be the case everywhere. What should happen is that we have a provision that ensures that ICPs have some focus not just on wider wellbeing but on the need to reduce inequalities and leverage the maximum social value for their area. There are huge amounts of money here and we must not underestimate—I am a firm believer in this—the power of procurement to be used positively for a community.

Has the Minister given any thought to what key values an ICP could champion when it is in operation? The amendment does not suggest the imposition of a chair or any particular arrangements as to how that is decided. That is why we have accepted for the purposes of ICPs the value of local solutions. Amendments 47 and 83 set out the minimum position that we think is necessary for ICPs to have real influence and not be just another talking shop. There has to be a process for disagreement to be flagged up and properly considered in a robust way that can actually change direction if required.

I hope the Minister takes away the point that I am trying to make and reflects on it, because it is not enough to just use the weasel words "regard to". That is just a given in my opinion. That just tries to pretend that something will happen when there is nothing to compel change.

There are wider questions about ICPs, which are set out in clause 20. How are they performance-managed? How do they run? Will there be funding for them to ensure that they can discharge their functions effectively? Presumably, they cannot provide other services, but will the Minister confirm that? Will they be able to form their own bodies themselves? There is plenty more where we need some meat on the bones. I hope the Minister will be able to provide that when he responds to our amendment.

Alex Norris Amendment 83 builds on my hon. Friend's argument about creating some balance between the integrated care partnership and the integrated care board, so I will not repeat it. I simply underscore the fact that the ICPs have the money, power and accountability at the moment, but there is a risk that they become a closed shop and not bodies about integration at all.

We are told that integrated care partnerships will be the way in which the broader health and care family and the community will come together as they lead and play a pivotal role. We need a safeguard in the Bill to ensure what we would do if the relationship breaks down. The amendment is a version of what Sir Robert Francis from Healthwatch said about one possible way in an evidence session. I am not prescriptive about this, but I am keen to hear what the Minister might suggest to give

[Alex Norris]

us comfort on this. If the ICPs are to function as promised, their plans ought to have some sort of status, so that if the integrated care board chooses to diverge, it must make a public statement that it is going to within 30 days and then publish its reasons with evidence within 60 days.

There is an equivalent provision in NHS England for responsibilities held at a national level. If nothing else, this is basic accountability. It does not restrict any activity, so there is no risk in it. Even if a partnership does not like the decision made or value the reasons given, it cannot remove the chair of the board. Although the constitution has already prevented that, at least we will know what has happened, so the safeguard is quite modest. There is a blizzard of different ways to do it, but I hope that we can have some comfort on ensuring a balance between the partnership and the board, if not at this stage, then by the time we come back on Report.

Karin Smyth: Will the Minister share with us what he thinks the difference is between ICPs and health and wellbeing boards?

Edward Argar: I will confine my comments to amendments 47 and 83, because we will address the wider themes when we have the clause stand part debate.

Amendments 47 and 83 stand in the names of Opposition Members. The shadow Minister, the hon. Member for Ellesmere Port and Neston, has asked a number of questions, which I will try to address before turning to the substance of those amendments. I am not personally aware of any analytical piece about the impact and effectiveness of health and wellbeing boards, but anecdotally from my background in local Government before I came to this place—and, indeed, as a Member—I certainly see the value that they bring to their communities through their work. The shadow Minister is perhaps being a little inadvertently unfair to the legal profession in suggesting that the phrase "have regard to" is weasel words, because my understanding is that "have regard to" is a well-known, much-used legal phrase in drafting, and it carries with it an obligation to do exactly what it says: to have regard, and to show that.

Finally, the hon. Member has pressed me again, and I fear I will give him the same answer—he and I have done this before—as I have given the other shadow Minister, the hon. Member for Nottingham North, in various delegated legislation Committees over the past year relating to our exit from the EU. I think the Prime Minister has been entirely clear in what he has set out: this legislation lays important foundations for the closer integration of local authority and NHS-provided care, on which we will of course build, because we are an ambitious Government with a clear agenda to further improve our health and care systems.

With those points made, I will turn to the detail of the amendments, which address the relationship between ICPs and ICBs—as certain Opposition Members have touched on—and address divergence from health and wellbeing board and ICB assessments and strategies. Amendment 47 would require the Secretary of State to establish a procedure to resolve any disputes between the ICP and the ICB, while amendment 83 would add an additional requirement on NHS England, integrated care boards, and local authorities to make a public statement and publish their reasons when they deviate from the integrated care strategy prepared by the proposed integrated care partnership, and the joint strategic needs assessment and joint local health and wellbeing strategies prepared by health and wellbeing boards.

I do appreciate the concern—the genuine concern, I think—from Opposition Members about the need to ensure that ICPs and local authorities are genuinely closely aligned to both the ICP and the health and wellbeing board plans. We do intend for these assessments and strategies to be a central part of the decision making of these bodies: that is why, as I say, we are introducing a duty for those bodies to have regard to them. However, we do not think the additional conditions suggested by these amendments are necessary, as we believe there are already means in place to avoid such disputes. First, the ICB will be a required part of the ICP. It will be intimately involved in pulling together the integrated care strategy, so it should be fully signed up to the elements of the plan that fall within its area of responsibility, as it will be partly drafting that plan. As a result, we consider the likelihood of disputes in that context to be low.

Secondly, there are already duties on both ICBs and local authorities to have regard to the strategy in discharging their functions. The duty to have regard means that to diverge from the plan, they must be able to reasonably explain and justify why they have done so. If they cannot, they would be open to challenge, and in the case of an ICB, they could be open to direct intervention from NHS England for having failed to discharge their functions to have due regard properly. Thirdly, we would also expect that both health and wellbeing boards and ICPs would consider how their strategies and assessments are applied in the system, and would want to keep progress under regular review. Those committees themselves provide an appropriate framework for regularly assessing and considering how to address any divergence.

We are also concerned that it would be difficult to rigidly determine if and when NHS England, an integrated care board, or a local authority had diverged from these strategies and assessments in the exercise of their functions, especially if plans were high-level and strategic. By creating this specific requirement and setting a specified timeframe, I fear we would risk creating a great deal of bureaucracy as these bodies attempt to determine if, when, and to what extent they may have diverged. Instead, we believe it is more appropriate to leave it to ICPs working with the ICB and local authorities to develop and design mechanisms to review progress locally.

As a further safeguard, NHS England has the general power to issue guidance to ICBs on the discharge of their functions, which could be used to set out how an ICB should consider the integrated care strategy, joint strategic needs assessment and joint health and wellbeing strategy in exercising its functions. Guidance may also suggest ways of resolving any issues that arise in the ICB in the exercise of these functions. We would expect NHS England to consider doing so, if that was necessary.

4.30 pm

Before I close, I will make one further observation. The relationship between the ICB and ICP is very similar in reality to that between CCGs and health and

wellbeing boards. Our experience there has suggested that disputes are rare, and in the vast majority of cases they have been resolved locally, without the need for any external intervention. Where that has been necessary, it has been mostly supported by peer brokering or collective compromise, not appeal to an outside authority. Although what we are doing here clearly moves us significantly further forward in integrating health and care in this country, we would want that sense of joint endeavour from the current regime to continue in and percolate through the new system.

I hope my comments give hon. Members a degree of reassurance and, as I have frequently done this afternoon, I will try to tempt Opposition Members not to press their amendments to a Division.

Justin Madders: The Minister has made some interesting points. I will have to come back on the reference to "weasel words". I was a lawyer for a number of years, and when it comes to their use, I think that lawyers are probably second only to Members of Parliament in being able to use them.

There were many occasions when we were negotiating and drafting documents. Once, I wanted something to happen and another person said, "Well, we don't want to actually make that an absolute commitment, but we intend to do it." We always ended up with the compromise of reasonable endeavours. Best endeavours was another one. Often that led to one side being slightly disappointed, but that was usually the point of compromise. But that, I would suggest, is actually going further than what is in the current legislation, which is to "have regard". That really is the nub of this, because we do not think that is enough to give the ICPs the teeth that they need and the strength and leverage that they might need if they are to be truly effective.

The Minister said that if there was a divergence, he would expect an ICB to put forward reasonable explanations as to why it was not going to follow a particular strategy. But that would then lead to the conclusion that if it was not able to do that, it was acting unreasonably, which of course could give rise to judicial review. That, I am sure, is a road that the Minister does not want ICBs and ICPs to go down. I do not think that would be in anyone's interest, so we are actually, once again, trying to help the Minister out by coming up with a solution that avoids litigation and dispute and gives us confidence that we will not see a repeat of the lack of genuine engagement that we have seen in some areas in the past, but will see a real force, in legislation, to encourage the wider public sector to have real influence on the modelling of health policies and strategies in the future. Therefore we will—with your permission, Ms Elliott—press amendment 47 to a vote.

Question put, That the amendment be made.

The Committee divided: Ayes 4, Noes 7.

Division No. 9]

AYES

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

NOES

Argar, Edward	Gideon, Jo
Churchill, Jo	Robinson, Mary
Davies, Gareth	
Davies, Dr James	Skidmore, rh Chris

Question accordingly negatived.

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

Edward Argar: The clause introduces the integrated care partnership known as an ICP, as a joint committee of the integrated care board and local authorities in its geography. It gives the partnership its core function of preparing the integrated care strategy. The ICP was developed with the Local Government Association and NHS partners in recognition of the fact that the system has been calling for two different and important types of integration: integration within and across the NHS to deliver healthcare services within a defined locality, and integration between the NHS and local government and wider partners.

The ICP is intended to bring together health, social care and public health to develop a strategy to address the needs of the area also covered by the integrated care board. If the ICP wants to go further, it can also involve representatives from the wider system where appropriate, such as voluntary and community groups, and social care or housing providers. That will be up to the ICP, and we will welcome locally driven innovation to reflect local circumstances.

When preparing the strategy, the integrated care partnership must take into account the NHS mandate, any guidance from the Secretary of State and any relevant local joint strategic needs assessment. The ICP must also involve the local Healthwatch, as well people who live and work in the area. The strategy will need to look at how local authorities and NHS bodies can work together using arrangements under section 75 of the National Health Service Act 2006.

Local authorities, integrated care boards and NHS England, when providing services in the area, must have regard to the relevant integrated care strategy when exercising their functions, as well as, more locally, any joint strategic needs assessment or joint local health and wellbeing strategies. This will enable more joined-up planning and provision, both within the NHS and in local authorities. As a result, we would expect to see more integration of the services people receive, more efficient and effective commissioning, and closer working between local authorities and the local NHS.

The clause makes it a legal requirement for all ICBs and local authorities to establish an ICP for their area. These partnerships will promote and facilitate integration across health and care throughout England, thereby contributing to delivering on the ambitious aims put forward in the Bill to further integrate health and care systems.

Justin Madders: I will not detain the Committee as I have already said most of what I wanted to say. The Minister just talked about the ambitious aims to achieve integration. Obviously, they were not that ambitious; if they had been, we would not need another White Paper.

Edward Argar: Even more ambitious!

Justin Madders: We can never be too ambitious, can we? I will be interested to see those working practices. As hon. Members can probably gather, we are somewhat sceptical that the ICPs will really be the transformative

[Justin Madders]

and influential bodies that we want them to be. I will keep a close eye on what kind of partners end up on them. If we started involving every potential body in the Cheshire and Merseyside one, we would probably need to hire out Anfield to fit everyone in. It might be more entertaining than the football fare on there—we could have a Division on that. We will probably revisit this in future days, weeks and months. We will not oppose the clause but we wish to put on the record where we think its shortcomings are.

Question put and agreed to.

Clause 20 accordingly ordered to stand part of the Bill.

Clause 21

NHS England's financial responsibilities

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

The Chair: With this it will be convenient to discuss clause 22 stand part.

Edward Argar: The clause provides for a number of financial responsibilities of NHS England and provides powers for the Secretary of State to direct NHS England in relation to those responsibilities. Clause 22 provides the ability to amend the provision in clause 21 that imposes a duty on NHS England to ensure that its expenditure, together with that of integrated care boards, does not exceed the sums received in a year.

On clause 21, proposed new section 223C of the National Health Service Act 2006 places a duty on NHS England to ensure that in each financial year, the expenditure of NHS England and integrated care boards does not exceed the aggregate amount received by them. It should be noted that that is in the context of the historic settlement for the NHS reached in 2018, which will see its budget rise by £33.9 billion by 2023-24. Proposed new section 223CA simply replicates a provision in the 2006 Act, which enables the Secretary of State to specify the banking facilities that NHS England may use.

Proposed new section 233D of the 2006 Act enables the Secretary of State to give directions to NHS England concerning resource use. Any directions given by the Secretary of State under that proposed new section must be published and laid before Parliament. Proposed new section 223E empowers the Secretary of State to direct that the capital and revenue resource used by NHS England and ICBs for specified matters does not exceed a limit set.

Clause 22 could be commenced at a later date than clause 21. It would expand the duty on NHS England to ensure its own expenditure, as well as that of ICBs and English NHS trusts and foundation trusts, did not exceed the sums received by those bodies in a year. The clause is essential to ensure that achieving financial balance is inclusive of the finance of NHS trusts and foundation trusts. It recognises that NHS England must be mindful of the need to ensure that public money is spent as effectively as possible and in the best interests of the public we serve. However, we recognise that the NHS is moving out of an unprecedented period, so we will not commence the clause until it is ready. The provisions will help to ensure that there is clear accountability for public spending and that the NHS lives within its means.

Justin Madders: I will talk briefly about clauses 21 and 22, although with your indulgence, Ms Elliott, I will step over into clauses 23 and 24, because we cannot really look at these points without having some regard to those clauses. I promise I will not repeat the same points when we get to them.

We know that ICBs and NHS trusts will have spending limits, and that in theory they cannot go into deficit in any year, but the combined deficits of trusts before the pandemic was several billion pounds. Foundation trusts are in a slightly different position. Monitor is going—clause 26, which I suspect we will not get to today, goes into that, and it reads quite brutally in isolation—so it needs to be clear in the Bill how performance management and financial oversight will work in its absence. We still have questions about that, particularly how accountability will work with those new systems.

We see in these clauses a basic tension that NHS England will apply totals to systems, but individuals within the systems all have their own duties and responsibilities. We might think it is the ICB plus all the providers that deliver the services required, which are paid for by the ICB, but I am not sure that is how it will work in practice.

If I am correct, an integrated system is not defined in the Bill, so how do we control something that does not exist in law? Where accountability lies is very vague. The terminology used in proposed new section 233M, which is where the Bill tries to constrain aggregate financial spending each year, is:

"Each integrated care board and its partner NHS trusts and NHS foundation trusts".

That suggests some kind of joint responsibility, but where community health services are provided by Virgin Care, that does not appear within that wording. GPs and their spend are considered outside, even though they are commissioned by the ICBs, so how do their costs fit into this system? There have to be some answers on that.

4.45 pm

We also need clarity on how NHS England will control the aggregate spending in any patch, because some trusts span more than one area. If we had coterminosity, that might not be such a problem. Can the Minister explain how that will be policed? Core specialist services are also sometimes delivered outside ICBs. How will that all fit in? If a trust or foundation trust wants to argue about its space allocation from the ICB, who is going to decide that? Will it be NHS England or the ICB? Can the Minister help us with that?

What will this all mean in practice? Each system constitutes ICBs plus the trusts, and has a limit. We do not know how ICBs will get their funding allocated. The trusts do not know how the money will be coming down to them and on what basis, because none of that is defined in the Bill. Where does the buck stop for those decisions? Who carries the can if there is an overspend?

What if commissioners and providers are on the same side? Where does the buck stop there? Can a system be put into special measures if it overspends? What if it is one rogue provider? Does everyone else have to bear the consequences of that? Do overspends get clawed back?

There are a lot of questions about how this will work in practice, and they go with the sense of uncertainty about exactly what ICBs will be doing when they are up and running. Surely, if an ICB exceeds its total, some kind of regime will have to apply. Will expensive consultants be brought in to tell people what they have done wrong and state the obvious? It is not clear to us what the levers are to apportion accountability and hold people to account. While we have a blurring of the lines between commissioner and provider, that will cause continued problems.

Rather than saying that we are fully against the proposals, we are saying that we do not understand how all this is going to work in practice. I hope the Minister will be able to shine a light on that.

Karin Smyth: I echo my hon. Friend's words. The Minister is going to have to go back to the drawing board on this, although I can see what the clauses are trying to do. Financial directors I have spoken to commend the idea of working together under some sort of shared control. We have had controls before, but clauses 21 to 24 —I may be straying beyond my knowledge of the writing of Bills and financial movements—come under the heading, "Integrated care system: financial controls", and the entire section is about controlling ICBs and NHS trusts.

We have not had a system defined. We know that control totals are difficult and that autonomous trusts have regulatory rules. We would be here all weekend if we started to talk about foundation trust controls, and what those trusts can and cannot do with their budget. Clauses 21 to 24 test out the definitions of roles and responsibilities, and the tensions throughout the Bill over trying to apply a systems view to disparate organisations with different duties and responsibilities. The Minister has been trying valiantly to say that there is clear accountability through NHS England, but all of us here as Members of Parliament, and as I keep repeating, understand what local accountability is in a system and this is not it.

We do not know what an ICS is, and we have all agreed that that might be okay—we are kind of in favour of permissiveness—but what divides the Committee and, I suspect, people farther afield is that the Government view is that permissiveness is okay, and it is up to the NHS England regions and the Secretary of State. We would like to impose some greater local accountability earlier.

The terminology in proposed new section 223M, on page 34 of the Bill, is clear, and refers to:

"Each integrated care board and its partner NHS trusts and NHS foundation trusts".

That part of the Bill deals with aggregated spending on revenue and capital. I do not want to overload people's brains at this time of the evening, but the Bill really is a mess in respect of capital. Our buildings are crumbling and the backlog is huge. We have talked about NHS properties in community health partnerships. The architecture still exists, but it is not clear how that system works. I think poor old Sir Robert Naylor's edicts and pieces of wisdom are just propping open doors in offices in the Department of Health and Social Care, because they are certainly not being developed and they are not being developed in the Bill.

Will a trust finance director have to seek permission from the ICB to spend their capital, or even to know what it is? If that is the case, it makes a nonsense of the good financial management of some very large institutions. We would all like a bit of financial rigour in the system, but I am not sure the Bill allows us to have any. It is as my hon. Friend the Member for Ellesmere Port and Neston said: for community services, we have the Virgin Cares, but even a community interest company would sit outwith the NHS trust definition. Such companies are regulated by the Office of the Regulator of Community Interest Companies, which is separate from some of this. The regulation for some of these bodies is problematic, and GPs are obviously outside it, even if ICBs start to commission them.

The aim is to allow NHS England to control aggregate spending, but to do that there has to be some direction. Lo and behold, on page 35 of the Bill there are more direction powers for NHS England. We have alluded to the fact that provider expenditure gets divvied up, and some ICBs also commission specialist services; there will have to be some NHS England-defined calculation of how on earth all that fits together. Someone somewhere will need a very large spreadsheet and will have to try to balance the flows of money around the system.

I have asked a lot people, including experts, whether anybody starts to understand financial flows. That is obviously important because we are talking about our taxes and we need to know how they are being spent, who is spending them and who is moving the money between each of these organisations. What about when these bodies cross different boundaries? Will the Minister say whether the trust or the foundation trust gets to argue about which part of its base is allocated to which ICB and vice versa? I am certainly glad—I often am—that I do not live in London and am not trying to work that out for some of the large teaching hospitals that cross many boundaries. There used to be a role for strategic health authorities to try to match what providers said was in their accounts with what commissioners said they thought they had given them. I do not think they matched that often, and the structure in the Bill is much more complicated than that. How it will work in practice matters.

My hon. Friend the Member for Ellesmere Port and Neston has already asked some of the questions. This issue is very complex and involves big sums of money, and ultimately it is about patient care, so who is going to hold it all together? Where is the collective leadership and who will be the top people in these ICSs? The advert for the ICS chairs has gone out, and the pay is £50,000 to £80,000 for three days a week. The requirement on those people is clear; let us see how many of them are not already well known to NHS England. That is deeply problematic, if they are going to work—and we all agree that we would quite like them to work.

In the new system, can commissioners and providers both be blamed for the same things? As my hon. Friend said, can they be put into special measures? Where are the levers? What is going to happen, other than NHS England commissioning expensive consultants to say to

[Karin Smyth]

people, "You know what? It's looking a bit complicated and some of you haven't got the right bits of money in the right places," and trying to bash some heads together? All that will be done behind closed doors.

When we get down to the money, permissiveness becomes a bit of a work of fiction. This part of the Bill needs to be looked at again, between its leaving this place and arriving in the other place, to get a bit more sense into it. As we all know, the guidance is going out there. This has been worked on by NHS England, so it could come back in fitter form. As I said to the witness from Oxfordshire last week, joint work and integration often fall apart ultimately because of the money. Any local authority financial director, any foundation trust financial director, any good hospital financial director and any community interest financial director will be looking, quite rightly, at their own bottom line at the end of the day, as that is their job.

It is entirely up to NHS England how it navigates this. It looks like clever financial leverage work, and I really do not think that it will work and it all needs to be looked at again. I return to my theme that this is why we need somebody independent and highly skilled working on behalf of the local community to make the ICS work, and not to have it, as a result, an NHS England outpost deciding how it moves money around the system. We need to understand the financial flows, and ensure that they work much better than is laid out in the clauses.

Edward Argar: I will be relatively brief because I am conscious of the fact that we have agreed to get through quite a few more clauses today, although I will try to address the points that hon. Members have made. One of the key issues at the heart of what I think the shadow Minister, the hon. Member for Ellesmere Port and Neston, was saying is around what happens if an ICB or a foundation trust spends beyond its limit. How does that work? What is the process? I am pleased that this brings some welcome clarity, rather than the fragmentation we sometimes see in accounting cashflow, following the cash processes at the moment.

First and foremost, local systems will be informed of their resource envelope at the start of the year and will be required to agree a plan that matches, or is within, that envelope. Therefore, all will start the year with a plan that sets out what is being delivered and how much funding they will receive to deliver those services. However, if overspends emerge within year, that should initially be resolved within the system by the individual organisation either finding offsetting savings or securing savings elsewhere within that system envelope. Through the financial duties imposed by the Bill, the system is encouraged to be collectively responsible for managing its funding envelope, moving away from what we often see at the moment, which is fragmentation in understanding how the money flows, and each organisation considering itself to a degree in isolation.

If the overspend cannot be managed within the system, NHS England and NHS Improvement can use the powers in the Bill to hold the system to account through mechanisms such as the system oversight framework and providing support via the recovery support programme, as well as more informal support from the local region. Additionally, individual trusts or FTs that are not working collaboratively within the system can be held to account using the provider licence and enforcement options available for breaches. Finally, of course, in extremis the Department of Health and Social Care can provide cash support to NHS trusts and FTs to ensure that services continue to be delivered.

The second concomitant part of the shadow Minister's question was what action NHS England or the ICB can take in response to financial difficulties. Financial performance will be monitored by both of them, and in the first instance any difficulties will be resolved locally. However, as I have set out, tougher mechanisms or sanctions can be imposed on trusts that are not meeting their reporting and financial accounting obligations under the clauses.

Question put and agreed to.

Clause 21 accordingly ordered to stand part of the Bill.

Clause 22 ordered to stand part of the Bill.

Clause 23

Financial responsibilities of integrated care boards and their partners

Justin Madders: I beg to move amendment 53, in clause 23, page 35, line 14, at end insert—

"(5) NHS England must publish guidance on the means by which an integrated care board, NHS trust or NHS foundation trust which believes its capital resource limit or revenue resource limit risks compromising patient safety may object to the limit set."

This amendment would introduce an objection mechanism when an Integrated Care Board, Trust or Foundation Trust believes its capital resource limit or revenue resource limit risks compromising patient safety.

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

Clause stand part.

Clause 24 stand part.

Justin Madders: With this amendment, we are probably having another bash at the debate we have just had to some extent, but we are also making an important point about patient safety.

5 pm

The amendment will insert a new line in clause 23 to require NHS England to publish guidance on how an ICB, trust or a foundation trust may object to any revenue or capital limits that are set if they believe such a limit risks compromising patient safety. I hope Members will see why we have tabled the amendment. The previous Secretary of State made patient safety one of his biggest priorities and we all know the history and the various scandals that were the origins of that. Patient safety remains a huge challenge in the NHS. It is an ongoing battle. We are still seeing about 30 never events every month, according to the most recent data. Of course, many of those will be attributable to individual human error, but even that can overlook systemic challenges that can contribute to mistakes of that nature being made: workload brought about by staffing challenges, be it vacancy levels or high turnover; or actual physical challenges with equipment or buildings. They can all play their part in undermining patient safety.

The amendment aims to ensure that patient safety is central to all considerations, not an afterthought after the finances have been dealt with. It also plays into the mystery about where exactly the buck stops, which, I am afraid, despite the Minister's best efforts, we are still no nearer to solving. We still think, from what we have heard, that ICBs will be passporting down to trusts their allocation from NHS England, as has previously been performed by CCGs. If that is not the case, however, what happens if they rob Peter to pay Paul, taking cash away from one trust to bail out another? What if they both end up saying that patient safety is at risk? We will then have three different bodies in disagreement and patient safety possibly being compromised. Who decides then? Who is the arbiter? Who makes the probably invidious decision of deciding where resources go? It may be that the answer is the Government would ensure that NHS England found enough resources to avoid that, but that is not in the Bill.

I am sure the Minister will say that such a scenario is very unlikely, but I refer him to the *Health Service Journal* article this morning, headlined "Everything up for grabs". Now, that sounds like a furniture store's bank holiday sales promotion, but it is in fact an article on the current financial position of the NHS. It quotes senior sources, including directors of NHS England, who say that its officials will now need to review budgets and service priorities to decide which could be met. The article goes on to say that several senior officials and close partners of the sector told the *Health Service Journal* that they thought that key long-term plans were now unlikely to be met given the lost time, additional demand after covid and other pressures from the pandemic.

NHS England officials will now consider whether they can bid for more Government funding, where they can find savings and what efficiencies they can expect from local NHS providers, whether to try to meet targets despite the circumstances, or whether to set out to Government publicly which objectives they cannot meet. One NHS England director said—this is where the headline comes from—that they were concerned their budgets would be cut and that, "Everything is up for grabs." A different director said it was doubtful, for example, that the long-term plan target and Government manifesto promise to increase the number of GPs by 5,000 could now be met.

The article also says that trusts are expected to be asked to plan to make unrealistic efficiency savings of 1.5% in the second half of 2021-22, which is likely to be confirmed in imminent NHS England guidance. A substantial efficiency ask is also now likely to be set for 2022-23. I do not know if the Minister will be able to comment too much on that, but it does draw attention to NHS England effectively bypassing ICBs and telling trusts what their budgets are. That does not seem to sit very well with the rhetoric or indeed the wording in the Bill. If the requirement to find 1.5% of efficiency savings is accurate, it would be a tall order given that funding settlements have consistently lagged behind cost pressures for over a decade now. It is all very good saying that efficiency savings have to be made, but, as the article says and with the context I have just set out, they are possibly unrealistic.

What we are trying to do with the amendment is avoid any difficulties that such an edict might cause by ensuring there is transparency and an assurance that when those sorts of conversations are had, people at the sharp end are not forced to compromise on patient safety in order to meet unrealistic, centrally set savings targets. I hope that the Minister will understand the basis on which this amendment has been tabled and that he will be able to provide some clarity and assurance that patient safety will not be compromised as a result of efficiency savings that are required of NHS providers.

Edward Argar: Clause 23 provides for NHS England to set overall system financial objectives for ICBs, NHS trusts and NHS foundation trusts, which must operate with a view to achieving these objectives. This includes the ability to set limits on local capital resource use and local revenue resource use for ICBs, NHS trusts and NHS foundation trusts.

Clause 23 removes the sections in the National Health Service Act 2006 relating to financial duties of CCGs and replaces them with new sections setting out the financial responsibilities of ICBs and their partners. Improving population health requires the breaking down of silos. Traditional financial control focused on individual providers and organisations artificially creates barriers and fragmentation that get in the way of high-quality care.

The new approach will help to break down those barriers by enabling NHS England to set joint system financial objectives for ICBs and partner NHS trusts and NHS foundation trusts, which must operate with a view to achieving these objectives. This includes the ability to set limits on local capital resource use and local revenue resource use for ICBs, and for partner NHS trusts and NHS foundation trusts. NHS England can also give directions to ICBs, NHS trusts and NHS foundation trusts on resource apportionment.

I turn to amendment 53, tabled by the hon. Member for Ellesmere Port and Neston. I am grateful to him for tabling it as it gives us an opportunity to air a number of issues. It would require NHS England to produce guidance to set out a process whereby ICBs, NHS trusts or NHS foundation trusts could object to their capital and revenue resource limits. Although I understand the motivation behind the amendment, which is about ensuring that the NHS has sufficient funds to deliver services safely, I do not believe that it is needed. The ability for NHS England to set system limits is important to enable systems to effectively plan their services and it enables NHS England to meet its obligation on delivering system balance and its broader obligation to taxpayers.

The decision to allocate revenue funding to systems is based on a weighted capitation formula, which produces a target allocation or "fair share" for each area, based on a complex assessment of factors such as demography, morbidity, deprivation and the unavoidable cost of providing services in different areas, meaning that systems will get funding linked to their individual needs. NHS trusts and foundation trusts will be represented on ICBs, so they will play a role in deciding how resources will be allocated within the system. They can raise concerns about proposals, including with regard to patient safety, as part of the decision-making process, although we do not consider that these clauses would put patient safety at risk. Capital allocations already include a funding element to address emergency or patient safety needs, based on planning information from systems. The funding element is intended to be used to address any issues that could arise, including in the context of patient safety.

[Edward Argar]

Furthermore, clause 24 futureproofs the ICB financial duties provisions. It provides for some of the provisions in clause 23 to be replaced and is designed to be commenced at a later date. Once ICBs and their partner trusts are deemed ready to take on greater financial accountability, clause 24 can be used to replace clause 23 with a new joint expenditure limit duty on the ICB and its partner trusts. At a time when it is considered appropriate, the clause will require ICBs and their partner NHS trusts and foundation trusts to exercise their functions in a way that ensures their expenditure when taken together does not exceed their income. The intended effect is that each local area is mutually invested in achieving financial control at a system level, meaning that public funds can be spent in a more sustainable, joined-up and effective way. This should enable a nimbler approach to expenditure where needs across the system can be addressed more flexibly and holistically.

Should unexpected needs for funding arise, there is another safeguard in place to allow NHS services to continue operating safely, as the Department can issue cash to NHS trusts and foundation trusts. For example, if emergency support is needed to address patient safety issues, trusts can apply for additional cash funding to safeguard delivery of care. It is for those reasons that I invite the hon. Member for Ellesmere Port and Neston to withdraw his amendment. I commend clauses 23 and 24 to the Committee.

Justin Madders: I do not know whether it is too late on a Thursday afternoon, but I did feel like I had wandered into an episode of "Yes Minister" there. I will not press the amendment to a vote, but I will read the transcript of what the Minister has said with some care over the next few days. I am not entirely clear that he has addressed the central points that were made, but we will no doubt return to this at some point anyway. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Clause 23 ordered to stand part of the Bill.

Clause 24 ordered to stand part of the Bill.

Ordered, That further consideration be now adjourned. *—(Jo Churchill.)*

5.11 pm

Adjourned till Tuesday 21 September at twenty-five minutes past Nine o'clock.

Written evidence reported to the House

HCB71 Care Quality Commission

HCB72 Dr John Holden, Chief Medical Officer at the Medical and Dental Defence Union of Scotland (MDDUS)

HCB73 Allied Health Professions Federation

HCB74 Nora Everitt