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Public Bill Committee

HEALTH AND CARE BILL

Seventh Sitting

Thursday 16 September 2021

(Morning)

CONTENTS

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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

(Morning)

[Mrs Sheryl Murray *in the Chair*]

Health and Care Bill

Schedule 2

Integrated care boards: constitution etc

The Chair: We are going to continue with schedule 2. I call Alex Norris to move amendment 34.

11.30 am

Alex Norris (Nottingham North) (Lab/Co-op): I beg to move amendment 34, in schedule 2, page 120, line 26, at end insert—

"(2C) The constitution must require integrated care boards, and any committee or sub-committee of the board, to meet in public and publish all papers and agendas at least 5 working days before each meeting is held."

This amendment mandates integrated care boards, and their sub-committees including "place based committees" to meet in public and publish all papers and agendas at least five working days before each meeting is held.

It is a pleasure to resume proceedings with you in the Chair, Mrs Murray. This is a resumption of our discussion on schedule 2, which lays out the rules under which integrated care boards must meet. For all the talk of local flexibility, the reality is that the regulations are quite tight in schedule 2; the amendment seeks to tighten them a little more, but not disproportionately so.

The amendment asks for two things: first, that the boards meet in public, and, secondly, that they publish their papers five days in advance. To start with meeting in public, it has been mentioned on a number of occasions that the 42 different integrated care boards are in different states of development. There will be systems that are well advanced and model good behaviours of transparency and accountability, but we have to set regulations to ensure a minimum floor standard, and this is what the amendment does.

For a struggling system, the worst-case scenario, as we have said before, is that it can become a closed shop of leadership appointed centrally by NHS England and the leaders of the big acute trusts, because it is they who have the power and the resources. We cannot legislate to improve the culture of those systems—that is not what legislation does—but we can ensure proper oversight to try to minimise the risk, and meeting in public is a good way to do that. Sunlight is the best disinfectant, as they say, and this will mean that the public have a good sense of what decisions are being taken in their interests.

A key part of that citizen oversight is to know what decisions are being taken and when. Including a provision in the constitution to publish papers with five working days' notice seems a good way to do that. I would argue that that represents rather basic good governance, so it is a very low bar to clear. We have spoken before about wanting to allow integrated care boards to be able to vary to fit their local circumstances, but I cannot see under what circumstances it would be desirable or relevant to vary the publication of that information. I do not think there are any local circumstances that would call for that. The requirement would mean that members of the public, elected representatives and those who represent staff or anyone with a general interest would understand what is going to be decided and when, and would give them the opportunity to make representations so that the board members are making decisions in the full knowledge of the facts and the views of the broader system.

In the amendment, that requirement also applies to all committees or sub-committees. This matters, because we heard in the evidence sessions that it is almost inevitable that every system will want to establish sub-committees, both thematic—we heard from the system in Gloucestershire about its primary-care themed one, which I thought was a very desirable way to use a sub-committee—or, inevitably, given what we have said about the size of the footprints of some of the integrated care boards, place-based. It is important that the provision applies to those bodies too.

The question matters even more to the integrated care partnership and its status, and I hope the Minister will be able to address it. My reading of clause 20 and proposed new section 116ZA of the Local Government and Public Involvement in Health Act 2007 states that this is a committee of the integrated care board and the local authority. I would argue that that remains an oddity, because the process was pitched to us on the idea that we have an integrated care board that will be the official NHS fund-holding body, but then we have the integrated care partnership that will provide the broader involvement on an equivalent basis, not as a sub-committee. I hope that point can be addressed, but nevertheless it will be important for that body that the public know what is being discussed and when. We will come back to clause 20, but the commitment from the Government that the meetings and papers should be public is a good thing.

Conceptually, the amendment lands the ICB and any sub-committees at about the level of an executive board of a council. That to me feels about right. The Minister may have reflections about circumstances where, by exception, the boards may need to meet in private for certain decisions, as local authorities would do. There are ways to do that for councils, so I do not think it is beyond our wit to do the same for these bodies, too. As a default, the basic principle of public meetings, with papers published five working days in advance, seems sound.

Karin Smyth (Bristol South) (Lab): I offer my support to my hon. Friend and agree with everything he said. There may be a response from the Minister, although I do not know what he will say, but there is some discussion that perhaps the amendment is not necessary, as this already happens and the Bill refers to publishing—but that is not true. There are exemplar trusts and bodies across the country that have a culture of openness, but NHS boards are secretive and protected.

We have numerous examples of whistleblowing and good journalism uncovering the depths of NHS bureaucracy. Boards with which I have dealings, not just locally in

Bristol, do a lot out of the public eye, and a culture of not liking scrutiny has evolved over a couple of decades, even though they should be really proud that people are taking an interest. We need to change that culture, and having a reference in the Bill would help.

Trade union colleagues have often come to me to complain about how they are blocked from getting key information about plans for changes. Changes are announced, and management often want to start TUPE discussions without really understanding what is behind the change. The use of freedom of information requests results in variations across the country in who responds and how they respond. That needs to stop.

The default should be to make things public unless there are reasons not to. I was a non-executive director back in the noughties, and was led by a chair who had come from local authorities—a Labour chair, but I do not think that matters. People who were used to chairing in local authorities found it quite peculiar that the NHS wanted to discuss matters in secret. As a board, we made it the case and culture that managers had to say if there was a really clear reason, and on several occasions we challenged why things were not done properly.

The new NHS is not commercial. The Government tell us that we are not quite getting rid of the purchaser-provider split, but we are moving away from competition as the driver of the health service. The confidentiality argument should be disappearing. I hope that the Minister accepts that the very highest standards now need to be set around openness and transparency and need actually to be enforced. All levels of the NHS and all these committees and sub-committees, however we end up organising them, have to be cognisant of the Nolan principles, which should drive all their work.

If a trust is finally forced by a tribunal to disclose information, it should have been provided earlier. There should be consequences. Where there is a bad culture, we need to change it. To reference my hobby-horse, there should be a business case to support every major decision. Later we will discuss my new clause 7, which comes from the pain I have experienced trying to unearth business cases, particularly in wholly owned companies and subsidiaries, to deliver facilities management. I have asked for business cases only to be told, "No, it is confidential." There should be no need for it to be confidential at all. I do not understand how a business case can be confidential—at best, a few lines might be sensitive, but not a full business case.

That shows that NHS bodies who fear a change think they have something to hide. It is wholly wrong. If a change is proposed, the case for change should be published. We need to know why it is necessary. I would go further; I would publish all details of the tender process and the contract management. If anyone wants to do business with the NHS, which we welcome, they need to be open and transparent. It really is a test of the intention to change course and move to an integrated, collaborative model, because as we exit the market, we need to be make sure that the wellbeing of the public and the patient really comes first in commissioning. As I say, that culture needs to be changed.

To come back to my theme, ICBs need to be the bodies that the public recognise and understand as being where some sort of accountability resides. That means that nothing should be secret. Let us go further: the public has the right to question. That is what we come back to. There has to be a figurehead—ideally an elected figurehead—or non-executive directors who can be truly independent and challenge that secretive culture. I hope the Minister will look favourably on the amendment.

The Minister for Health (Edward Argar): It is a pleasure once again to serve under your chairmanship, Mrs Murray. I am grateful to the shadow Minister, the hon. Member for Nottingham North, and to the hon. Member for Bristol South for their amendment, and for their comments on it. As the shadow Minister set out, it would require ICBs and their subcommittees to meet in public, including place-based committees. To address one of his specific points, if I understood what he was saying, I think he does interpret it correctly: the ICP is a committee of the ICB, albeit a joint committee with a whole range of other organisations. I would expect the same principles to apply to it as to the ICB, and I will go through those in a second. The amendment would also require all papers and agendas relevant to those meetings to be published

"at least 5 working days before each meeting is held."

We agree with the shadow Minister that it is right that ICBs involve the public in their decisions, and do so in a transparent and clear way. I hope that I can offer him some reassurances that the Bill already provides much of what he is asking for. Like a number of hon. Members, I served on a primary care trust board as a non-executive director, back in the days when I had more hair and it was not grey—although that might have been just a day ago, before reshuffle speculation—and I take the point that the hon. Member for Bristol South has made. We sought to be as transparent as possible, but there were occasions on which total openness to the public about consideration of certain items would not have been appropriate. I will come to those in a second.

In terms of what is already provided for, the Public Bodies (Admission to Meetings) Act 1960 already places on such bodies a set of requirements to involve the public in meetings that is very similar to those in the amendment, and I suspect that Act was part of the genesis of the shadow Minister's thinking. The Act requires meetings to be held in public, for the public to be made aware of the time and place of the meeting, and for the agenda to be published, alongside any reports or documents relevant to the agenda items. ICBs have already been included in the Act by the consequential amendments in schedule 4 to this Bill, and we may want to connect that loop up when we reach schedule 4, hopefully later today—I believe that is the intention. By using that legislation, we keep ICBs in line with the requirements placed on other public bodies, meaning that there is consistency across public bodies and they are held to the same standards.

I hope I can give some further reassurances that there are broad duties on integrated care boards to involve the public in the decision-making process, over and above those contained in the Act. Clause 19, which inserts proposed new section 14Z44 into the National Health Service Act 2006, places a duty on integrated care boards to involve and consult the public in the planning of commissioning arrangements, including in respect of any planned changes to those commissioning arrangements. This will ensure that the voices of residents—those who access care and support, as well as their carers—are properly embedded in ICB decision making.

[Edward Argar]

Schedule 2 to this Bill, which concerns the constitutions of integrated care boards and which we will reach shortly, states that ICB constitutions must specify how the ICB plans to discharge its duty to involve and consult the public. Moreover, those constitutions must specify the arrangements that the ICB will make to ensure that there is transparency in its decision making, and NHS England will ensure that all proposed constitutions are appropriate and include the relevant provisions to meet those obligations. Under clause 13, which inserts proposed new section 14Z25 into the 2006 Act, NHS England will need to approve the constitution when making an establishment order, and proposed new section 14Z26 makes it clear that NHS England has the power to reject a proposed constitution if it does not meet the appropriate bar.

Turning to a few specific points made by the hon. Member for Bristol South, we are still clear that competition has a role to play in this space: it is about proportionality, and seeking to achieve a better and more proportionate balance in that respect. She rightly asked about the examples of circumstances whereby it might not be appropriate to be fully transparent. I was on a primary care trust board some years ago, and there were occasions when the board would discuss specific incidents or situations that could lead to the identification of an individual or a group of individuals. Clearly, such matters would be confidential. Similarly, matters that were due to be, or were, before the courts were discussed on occasions—again, we would expect that to be confidential.

11.45 am

Given what I said about competition, I still believe that there is a case for a degree of commercial confidentiality during a tender process, as sometimes releasing all the information at an early stage could lead to giving those tendering an advantage over the organisation. If a budget is set out, some organisations might bid up to that budget, rather than putting in what they think is the appropriate price, so there are examples—I would hope they were limited—where I believe there is a case for confidentiality.

To summarise, I endorse what the shadow Minister and the hon. Member for Bristol South were saying, which is that the principle of transparency is one to which I think we would all expect these bodies to fully adhere. On that basis, I gently encourage the hon. Member for Nottingham North to consider not pressing his amendment to a Division.

Alex Norris: I am grateful for the contribution from my hon. Friend the Member for Bristol South. I completely agree that where we will see the worst practices across footprints, each and every one will be secretive and not invite scrutiny, so it is very important that we set arrangements to ensure that that cannot happen.

I am grateful for the clarification that the 1960 Act will apply, which assuages my first concern. On the second, relating to the notice of board papers, the Minister has essentially said that local footprints will have to set that element of the constitution themselves, but that the safeguards and schedules will mean that NHS England has to sign them off. In that sense, there cannot be wide divergence, because the centre would not permit it. I reiterate that there should be commonality. I cannot see why it would be seven days in one place and five days in another. I do not know how we could explain that, so I hope that in those conversations the Minister stresses the need for uniformity. Perhaps the guidance might include strong encouragement on that. On the basis of the agreement that we have in principle, I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Justin Madders (Ellesmere Port and Neston) (Lab): I beg to move amendment 43, in schedule 2, page 123, line 2, at end insert—

"(5) An integrated care board must apply all relevant collective agreements for staff pay, conditions and pensions.

(6) An integrated care board must ensure that all relevant collective agreements for staff pay, conditions and pensions are applied throughout the area for which it is responsible.

(7) Any integrated care board which wishes to employ anyone directly on an annual salary greater than £161,401 must receive approval from their integrated care partnership before confirming the appointment."

This amendment puts into primary legislation the current practice that NHS bodies honour collective agreements over staff pay and conditions and gives the integrated care board a role in ensuring this remains the case.

It is a pleasure to see you in the Chair, Mrs Murray. I would like to say that it is a pleasure to see the Minister, although when I saw the headline that two Ministers from the Department had been promoted to the Cabinet, I had expected that he would be among them—alas, not on this occasion. I am sure it is only a matter of time. Of course, if the Minister and other Members on the Government side want to keep their phones on in case a call comes through, we will not be offended if they have to pop out for a couple of minutes. I hope the Minister's rush of blood and damascene conversion to the perils of privatisation at the end of the sitting on Tuesday have not blotted his copybook too much.

I turn to amendment 43, which plays into several points that have come up in the evidence sessions, particularly the anxiety that was mentioned by Sarah Gorton of Unison in her evidence to the Committee last week. She said that she wanted to see in the legislation confirmation of assurances that have been given verbally and in guidance. She referred to conversations that she had had—I am not sure with whom, but I assume with officials in the Department. Those conversations were to the effect that there was

"no intention for any new parts of the system to undermine the collective arrangements".—[*Official Report, Health and Care Public Bill Committee,* 9 September 2021; c. 96, Q129.]

and that the "Agenda for Change" agreement would continue to apply across the board and, indeed, to ICB staff. That is an important matter to seek assurance on. Anyone who has been involved in "Agenda for Change" will know that years of hard, torturous work were involved in getting that agreed. Certainly, on this side, we know the value of the staff and their trade union representatives, and the importance that collective agreements have in bringing issues to the fore and ensuring a universality in treatment and a common understanding of the basis on which the employer and employee move forward.

Of course, whatever the collective agreements say, the staff would like to be offered increases that actually keep pace with the cost of living, rather than the real-terms cuts that we have seen in the last decade. However, as an

overall framework for ensuring staff are treated fairly and consistently, it is certainly not something that we want to be chipped away at.

I will not try to persuade the Minister of the benefits of collective agreements across other sectors—it would be well outside the scope of the Bill—but it is worth pointing out that there is plenty of evidence from across the world showing that where workforces have negotiated terms and conditions within sectors and across whole industries, they tend to enjoy better terms and conditions and, crucially, better rates of workplace satisfaction and staff retention. As highlighted in the report recently published by the Health and Social Care Committee, the NHS faces an enormous challenge in retaining its workforce.

We do not want anything to undermine "Agenda for Change". Sadly, though, we have seen attempts to do that in recent years, with the creation of wholly-owned subsidiary companies. I will not return to the argument about whether those are a good thing, because we have said that they are not, but let us examine for a moment why trusts sometimes seem eager to set these companies up.

There are, of course, huge financial pressures on trusts. I will not rehearse the arguments on that, but they are always looking at ways to reduce their costs, and potentially with these subcos to boost their income. The VAT advantages have been a big part of that, but one of the big concerns—cash-pressed trusts may see this as a big opportunity—is that the subcos potentially have the ability to move away from "Agenda for Change". That is the heart of it; it is not that the trusts have a major objection to "Agenda for Change", but moving away from it allows them to set their own terms and conditions, which is really a euphemism for saving money and cutting pay. We think that that kind of approach is a false economy and, ultimately, self-defeating.

There are other examples of where the private sector will step in. We saw the news this week that King's College Hospital Foundation Trust will transfer staff at its urgent treatment centre in Denmark Hill to Greenbrook Healthcare under a three-year contract, starting in October. Of course, staff will expect TUPE to apply, but, as we know, it is not a panacea. It does not protect terms and conditions for ever more, so it is little wonder that the news of that change has led the workforce to raise concerns.

Unison's written evidence sought clarification from the Minister that

"it's not the intention that ICBs depart from Agenda for Change",

which the Minister gave on Second Reading. The written evidence also states that

"UNISON would support amendments to ensure that ICBs will apply the relevant collective agreements for staff pay, conditions and pensions, and be responsible for ensuring that these are applied within the wider system. In addition, further reassurances should be sought that nothing in the Bill will compromise the assurances already given in the Employment Commitment, the terms of which should endure beyond the point of staff transfer."

The evidence continues:

"Recently published guidance lists 10 'outcome-based people functions'"—

perhaps that phrase could be translated into plain English at some point—

"that ICSs will be expected to deliver from April 2022… In addition, the guidance suggests that the responsibility for engaging with trade unions will rest with the regional teams of NHS England / Improvement rather than with ICBs".

That runs the risk of depriving unions of access to those who might be making strategic decisions in their area—or perhaps it just speaks to a larger truth about where power will lie in all this. We have covered those concerns in our amendment to some extent, but we would like reassurance from the Minister on some of the points we have raised about how this will all work in practice.

In particular, we need reassurance that the system will not undermine existing provider responsibilities on engaging with trade unions. As hon. Members will know, the vast majority of NHS staff will not be employed in commissioning bodies such as ICBs. The strong relationships with individual provider organisations should be a supplement to existing national and regional partnership forums. The concern is that the new kids on the block, the ICBs, will in some way disrupt those arrangements.

If, as we are told, the new ICSs—to use the correct terminology—will be system leaders themselves, it is not impossible that some of those leaders will want to set their own path in tweaking employment matters. We might see circumstances in which some agreement about staff mobility within ICSs comes to the fore, particularly for those whose duties cross organisational boundaries. In principle, that is no problem, as long as no ICB thinks that, as a result, it can move outside existing collective agreements. Our amendment would rule that out.

It is essential that ICBs have a positive role in all this and that they follow existing practice by referring to collective agreements. We would not want a re-emergence of what we saw some five years ago, with certain trusts trying to undermine collective terms and conditions. Those attempts failed, but we never know when that might re-emerge. We also believe that the ICB should honour national agreements for the staff it employs.

That should not need to be said—as we have heard, assurances have been given—but it needs to be made explicit in the Bill to give us the cast-iron lock that both we and Unison would like. We would certainly like some further assurances about whether the ICBs have the potential to circumvent or destabilise existing arrangements, should they seek to forge their own path at some point. We see this amendment as bolstering the commitment to "Agenda for Change"—I hope that the Minister will confirm that commitment when he responds —so that ICBs' broad powers are not seen as an attempt to undermine or conflict with the hard-won terms and conditions that have been collectively agreed.

Turning to sub-paragraph (7) in the amendment, which relates to pay limits, hon. Members will have seen headlines in the paper, on Tuesday, I think, about the highest-paid NHS managers being "cleared out"; I think that was the term that was used. I am not quite sure what that means, other than redundancy. The story refers to a Government-inspired audit, which was—at least on Tuesday—going to be led by the then Chief Secretary to the Treasury, the right hon. Member for North East Cambridgeshire (Steve Barclay), who has since moved on to other matters. That is a shame, because he used to hold the same role as the Minister does now, and he would know exactly where to look if there were indeed examples of unnecessary management and bureaucracy in the NHS.

[Justin Madders]

That news follows the headlines we saw last week about some ICB executives potentially receiving salaries of £270,000. Let us be clear what we are talking about here: that is the pay of 10 nurses. It seems that someone somewhere in Government is exercised about the number of managers in the NHS, but according to the King's Fund, the actual figure is somewhere below 5%, and many of those managers hold dual clinical roles. If the Government think there is a problem here, I am not entirely clear what they think the scale of it is, or what the consequences would be if thousands of managers in the NHS were made redundant. I am sure that was not covered in the impact assessment, but we have the benefit of that now.

To be clear, the amendment is not about bashing managers at all. Every organisation needs managers if it is to be effective, and they play an important role in enabling clinicians to get on and do their jobs on the frontline. I am sure the Minister would not want to leave managers in the NHS with the impression that has unfortunately been left by some of the headlines this week, namely that there is no role for managers in the NHS. One could be forgiven for concluding that from Tuesday's headlines. If the Government think layers of management, bureaucracy or management costs have got out of control, we can do something about it.

12 noon

If the Government had listened to us in 2011 and 2012, we might have saved billions already, because we would not have spent it all on lawyers and procurement processes that were introduced as a result of the Health and Social Care Act 2012. I urge the Minister and his colleagues to listen to us and adopt proposed sub-paragraph (7), which would have the effect of requiring approval from an ICP for anyone to be employed by an ICB on a salary of above £161,401. Studious Members will note that that figure has not been plucked out of thin air; it is indeed the current salary of the Prime Minister. We know that he does not think that that salary is sufficient for the job he does, but that is not something we can debate today. What he gets as the leader of this country is a significant figure, and we believe it is reasonable to say that if any ICB wishes to appoint someone on a salary above that threshold, it should have the wider consent of the partnership.

It was of interest last week that none of the witnesses was able to quantify the total cost of this reorganisation and development, and the impact assessment I have referred to does not set out any costs. One would assume that the Department will not be issuing a blank cheque, and I hope the Minister will be able to set out in detail what cost assumptions have been made. If not—I suspect we will not get the clarity we need—I propose amendment 43, which would bring accountability and financial rigour to a Bill that, at the moment, is sorely lacking in both.

Edward Argar: I am grateful to the shadow Minister, the hon. Member for Ellesmere Port and Neston, for his remarks on the amendment. I echo some of his comments, which we covered on Tuesday in Committee in response to the intervention by the hon. Member for Bristol South. Members on both sides of the Committee made clear our recognition of the value we place on those who work in the NHS, irrespective of whether they are managers, in clinical roles or in any other role. In our exchanges, we recognised the centrality of having good, high-calibre managers for what we all know is a huge system.

Amendment 43 would have two effects. First, it would require ICBs to apply to their staff all relevant collectively agreed terms on pay, conditions and pensions. Secondly, it introduces new rules for oversight of pay for the most senior ICB staff. The Government and the NHS remain committed to the principle of "Agenda for Change". If it gives the hon. Member for Ellesmere Port and Neston further reassurance, I am happy to write to him, because this is a detailed point and I suspect he may wish to have something in black and white that sets out exactly our position on this. We recognise—he alluded to this—that there is a need for a degree of flexibility in some circumstances. He talked about people moving between roles, secondments and so on. I will turn to that in a moment before turning to the point about pay.

There is already a commitment in the ICS HR framework technical guidance that staff transferring into ICBs will transfer across on their current terms and conditions, in line with the "NHS Terms and Conditions of Service Handbook" requirements. The commitment states that NHS pension rights will be preserved, as the individual will continue to be employed within the NHS, ensuring that staff transferring into ICBs will benefit from that protection and will not see any change to their existing conditions. Furthermore, we would expect ICBs to use the nationally agreed pay and conditions framework for the overwhelming majority of the time.

The hon. Gentleman referred to some flexibility, and he was right to do so. There may be circumstances in which an ICB needs flexibility to recruit staff, to attract staff with very unusual or valuable skills, or to reflect local circumstances and the availability of certain staff. Therefore, an ICB may need to vary the terms and conditions in order to make a post attractive if the marketplace is very competitive. Equally, the Bill provides valuable flexibility—for example, in order to allow ICBs to employ on secondment staff who have previously been employed by a foundation trust or local authority. Given the emphasis that the Bill places on systems working collectively and sharing staff, that is a useful flexibility. I would argue that such flexibilities are not unique, because NHS foundation trusts also have a degree of discretion in adopting such conditions, although they overwhelmingly choose to honour and keep the existing terms and conditions.

If I recall correctly, the hon. Gentleman asked specifically about the view on the involvement of unions and staff where there was divergence or flexibility. I would hope that where there was any divergence or a need for flexibility, that would be addressed collaboratively. Ideally, there should be consent from those working in the organisation as well.

I turn to the proposals for very senior managers. I believe that procedures are already in place to ensure that the most senior staff within the NHS are appointed with fair and equitable salaries, and proposals to pay very senior staff more than £150,000 a year must follow benchmarks or be subject to ministerial oversight. Ministerial oversight of salaries higher than £150,000 a year has been effective in managing the risk of salary escalations, and it provides for a national outlook across the public sector.

The hon. Gentleman referred to the former Chief Secretary to the Treasury, my right hon. Friend the Member for North East Cambridgeshire, who is now the Minister for the Cabinet Office. I do not think there is any inconsistency in what my right hon. Friend envisaged with the review. That should not be interpreted as a criticism or an attack on hard-working staff, but given the amount of money that is spent in our NHS on salaries at all levels, it is right that from time to time the Government look at that, review it and reassure themselves that the appropriate balance is being struck between fair remuneration for the work that is being done and value for taxpayers. I do not think I would read any more than that into it; it is simply the Government and Treasury being responsible with public money.

The hon. Member for Ellesmere Port and Neston will be aware that the Government are in the process of finalising the system for pay oversight that will apply to ICBs. Although the specifics may differ, the effect and intention will be the same: to afford ICBs a degree of agency and flexibility, so that we can continue to attract the most senior and experienced leaders, while also ensuring that we put adequate checks and balances in place to ensure that public money is well spent. Therefore, I would argue that the amendment is unnecessary. Once again, I gently encourage the hon. Gentleman to consider not pressing the amendment to a Division.

Justin Madders: I am grateful to the Minister for his comments, but I fear that I will disappoint him on this occasion. He mentioned the flexibilities that already exist, which we do not seek to change. I do not see anything in the amendment that would alter those. We have had a very clear commitment, and he has mentioned the guidance. Indeed, he may write to me—

Edward Argar: As I do regularly.

Justin Madders: As he does regularly. I write to him regularly, too. He mentioned the importance of having this in black and white, and that is where we agree. We do need this in black and white, and the place for that to be is in the Bill, so we will press the amendment to a Division. I understand what he has said about ministerial oversight of ICB salaries, but if these bodies are to be locally run and accountable, we think the amendment would be entirely consistent with that aim.

Question proposed, That the amendment be made.

The Committee divided: Ayes 5, Noes 9.

Division No. 6]

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.

Karin Smyth: I beg to move amendment 17, in schedule 2, page 124, line 14, at end insert—

"(7) An integrated care board may enter into an externally financed development agreement in respect of any Local Improvement Finance Trust relevant to the area for which it has responsibility and receive the income related to that agreement.

(8) An integrated care board may enter into an externally financed development agreement in respect of any proposed Local Improvement Finance Trust relevant to the area for which it has responsibility."

This amendment would enable integrated care boards to participate in existing and future LIFT schemes and to receive the income that would come to the local area from the local investment in such schemes.

I assure the Minister that this as a probing amendment, and I will not seek to divide the Committee, but it is an important issue. The local infrastructure finance trust transformed the primary and community based services in large parts of the country, and certainly in Bristol, over the noughties. In my constituency, there is a very large general practice community base, as well as South Bristol Community Hospital with the long-campaigned for urgent care centre and several rehabilitation and prevention beds used by the community trust out-patients. However, they have all hit problems in the last decade and have not really fulfilled their potential within the system, largely because many of them came on stream at the time of the Lansley Act and the abolition of primary care trusts.

The management of estates generally is something I have spent a lot of time unravelling. There is nobody locally spearheading them, really understanding the different, sometimes complicated, relationships within them and making them fulfil their potential, in terms of both delivering services locally and the financial model. There has been a lot of buck-passing locally about who is responsible for developing those things, and that is particularly true of my local community hospital.

My concern is that the wording in the Bill around "externally financed development agreements" is the same as was applied to clinical commissioning groups after the Lansley Act. The Bill also does not deal with NHS Property Services or community health partnerships, which are outwith the Bill. I wonder how these local ICBs are going to manage capital and estates development with the inherited part of that architecture. We will come later to the management of capital to develop the estate.

My concern is around how we get capital investment into primary and community care. In our evidence session, we asked the new chief executive how she saw this happening. I appreciate that we talked about large hospitals, even though we do not seem to know what a hospital is these days, but my point was really about community services. Ms Pritchard said that development would happen through

"the existing capital allocation processes… Rather than just going to each individual organisation to then make their own decisions about how they spend it, it would now go through the ICB, so there is a process that allows consideration in the round of how the system spends that money most effectively on behalf of its entire population."—[*Official Report, Health and Care Public Bill Committee,* 7 September 2021; c. 21, Q25.]

We will have some discussions around further clauses about the treatment of capital, but they do not really allow for the principles around the Local Improvement Finance Trust and primary care to develop. How do we get this investment into primary and community care? What is the Government's view on the LIFT model?

12.15 pm

When we transformed some of the estate in Bristol, it was about bringing local people—that is the "L" in LIFT—to the community and GP services. A dividend was also paid back to the local community, which I have discussed in this place on several occasions. I would quite like our money back for the local healthcare system. It was squirreled away outrageously under the Lansley Act somewhere in London.

Community health partnerships never thank me for raising this issue. Because I have raised it a lot, I have had many robust conversations—I call them robust, but they are more friendly—with the leaderships of NHS Property Services and community health partnerships over the management and treatment of the estate facilities in my constituency. I am impressed at how they have developed over time and how they, much like the rest of the NHS, have managed to work their way around the architecture this place legislated for, in order to improve the estate. As we all know, we cannot have a health service unless we have a decent estate. I also pay tribute to estate leaders, who pulled out the most incredible work in the pandemic to provide vaccination centres, move patients around and develop new facilities.

There are some fantastic examples around the country of plans that are place-based—the thrust of the Bill—and of people coming together to maximise use of the estate. In principle, the public-private partnership around LIFT, the involvement of the community and the paying back of the dividend help some of that. My question to the Minister in this probing amendment is, who do the Government see submitting business cases now for new primary and community estates? What is he expecting in terms of further investment?

I made a throwaway comment about what a hospital is, the 40 or 48 and what they are, but the Government have got themselves into a bit of a mess about this now. All hon. Members will have examples from our own constituencies that we can raise. LIFT is a way to manage some of these issues, and it does not go through the same process of capital. What is the further investment? How can I ensure that Bristol gets its dividend back from the LIFT scheme? That might be beyond the Minister's wit now. But on a serious note, the people providing the bulk of our health services in community and primary care deserve to understand how they can have better estates over the coming years.

Justin Madders: Particularly in light of the changes that have been made with covid, one thing that has cropped up locally is that a lot of GP practices—they are basically converted houses—simply are not designed with the ventilation or space to ensure there is a safe distance between people. That points to the importance of this issue and the need for clarity on how we get these estates into a state that is fit to deal with covid.

Karin Smyth: I agree, and we will probably all have examples through the primary care networks of practices that were not in old houses but that had perhaps had a LIFT scheme or another new development. In my constituency, the Bridge View Medical practice was able to have a flow through the building and move patients downstairs because it had a large, fairly new building. The pandemic has shown that in an emergency we need to make sure that the community-based estate is brought together in some way. Actually, that applies not just to the health service, but to ex-local authority or even Ministry of Defence or other Government Department estates. The place-based aspect of the Bill should be encouraging people to do that locally. Because estates are not part of it, they will struggle to deliver on the service intent of the Bill.

Alex Norris: I am grateful for the opportunity to comment on amendment 17 and the insight that my hon. Friend the Member for Bristol South brings from her long period of working in the NHS. What is at the crux of this point is quite important. We have spoken quite a lot about integrated care and revenue, but the capital component is as important, so I am glad we have the opportunity to discuss it.

I have great affection for the Bulwell Riverside facility in my community, which co-locates two GP surgeries, community services and pharmacy services with local authority neighbourhood services, the local library and youth services. Pre-covid, I and the local councillors would be there every week for an event. Every year, my annual jobs fair is there—it is today, but we are not inside because of covid, so it is out in the marketplace. If any of my constituents are watching, we are there until 2.30 pm.

That joint service centre has driven a culture of integration and collaboration, exactly in the spirit of everything we have been discussing on the Bill. It is a very practical example of integration in practice. It was funded on the LIFT model because, at that point, more than a decade ago, that was the way to get money into the system. The logical consequences on the ground of the legislative direction that we are told is intended here will be more need for this sort of joint service centre model. We need to give that proper consideration.

As my hon. Friend the Member for Bristol South said, this element is one of the few bits of the 2012 Act that is not being removed to take us back to pre-2012 status. Then, primary care trusts could enter into these arrangements locally, whereas their successors, clinical commissioning groups, could not and, at the moment, the successor ICBs cannot either. The amendment would remedy that.

Why is that provision not being added back in? It looks a bit like a wheeze. Originally, PCTs would have had a 40% stake in the arrangements and would have benefited exactly as my hon. Friend said. Now, that stake is owned by community health partnerships. Who owns 100% of community health partnerships? That is the Department of Health and Social Care. It is not that nobody benefits from these arrangements—it is that the Department does, rather than local communities. We are told this Bill is about localisation and devolving resources and powers to local communities, so why on earth is this bit not going back in? It is definitely a point of interest, particularly with existing LIFT models.

On LIFT models, it may be that the Government do not think that they are in vogue now or that they are the right model. I would be interested to hear what other methods the Minister might prefer.

How to get capital back into the system is a significant point. The NHS backlog is now £17 billion, as the bill for austerity becomes due, so we will have to address it by one means or another. If that is not to be done through this system, I am keen to hear from the Minister how it is to be addressed.

Edward Argar: It is right that we discuss this point today, because while the focus of the media is often on the 40 new hospitals being built—a very clear and understandable definition; I am sure any reasonable person could recognise a new hospital—we do not talk as often as we should in this place about primary care. It is often neglected in discussions, debates and headlines. It is right that we are talking about it today.

On the shadow Minister's point about CHPs and similar, the Department exists to further the health of the population and to support local communities. There is a wonderful synergy in those objectives and outcomes.

I will turn to the substance of the amendment tabled by the hon. Member for Bristol South who, on this as on many things, knows of what she speaks, with her depth of experience in this space—I always tread slightly warily when responding to her challenges. As she alluded to, the amendment would allow an integrated care board to enter into an externally financed development agreement in respect of any Local Improvement Finance Trust relevant to the area for which it has responsibility, and to receive the income from that agreement.

We believe that the amendment is unnecessary, as the ability to enter into an externally funded development agreement is already covered by provisions in paragraph 20 of schedule 2. The provisions allow an ICB, which would take the local view of estates and other health matters,

"to enter into externally financed development agreements"

if the agreements are

"certified as such in writing by the Secretary of State."

Such certification will be considered if

"the purpose or main purpose of the agreement is the provision of services or facilities in connection with the exercise by an ICB of any of its functions, and…a person proposes to make a loan to, or provide any other form of finance for, another party in connection with the agreement."

We are clear that the wording of the provision would encompass a development agreement entered into with a LIFT company. If included separately in the Bill, as the amendment proposes, there is a risk that the interpretation of paragraph 20 of schedule 2 is that the Bill's intention is to restrict the use of externally financed development agreements to those that involve taking a shareholding in LIFT companies, which is just one type of project company model that could be used to access private finance. That is why we believe that the amendment introduces a degree of ambiguity that is not currently there.

On the broader points raised by the hon. Lady about who has responsibility for the primary care estate and for investing in and upgrading it, she will be aware that it is a complex picture because of the nature of some GP surgeries—some own their own buildings, others will be in a health hub. My hon. Friend the Member for Bury St Edmunds—we remain ministerial colleagues in the same Department for the moment, but who knows what the future may bring—has done a huge amount of work with primary care to look at those challenges.

The hon. Member for Bristol South talked about hubs, or integration. One of the models being looked at—all the credit must go to my hon. Friend for this work—is the so-called Cavell centres that hon. Members will have read about, which are about looking at how we could have health hubs in town centres, bringing together a whole range of services. They are at an early stage of development, but it would be remiss of me to pass over that point without paying tribute to my hon. Friend for her work in that space.

On LIFTS more broadly, we are not envisaging any changes to existing LIFT company arrangements. They can still be used for the purposes for which they were originally set up. The hon. Lady has kindly indicated that she does not intend to press the amendment to a vote, but I hope that I have given her some clarity, particularly on why we think the provisions in paragraph 20 of schedule 2 will cover and continue to allow the arrangements to which she alluded.

Karin Smyth: I am grateful to the Minister for his comments, which I will read and understand carefully. We would still like our dividend back; it is an important principle of localism and, dare I say, accountability. We promised people that that is what they were getting. I will continue to pursue the matter in this place, but I am grateful to the Minister for his comments and, as I said, I will not seek to divide the Committee. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Question proposed, That the schedule be the Second schedule to the Bill.

Edward Argar: The schedule details essential information about how we expect statutory ICBs to function and about the essential criteria that ICB constitutions must fulfil. It sets out that ICB membership must, at a minimum, include a chair, a chief executive, representatives from local NHS trusts and foundation trusts, primary medical service providers and local authorities, known as "ordinary members".

The chair must be appointed by NHS England and approved by the Secretary of State. The constitution must not provide for anyone other than NHS England to remove the chair from office. The power for NHS England to remove the chair from office must be subject to the Secretary of State's approval. The chief executive must be appointed by the chair and approved by NHS England.

The ordinary members of the ICB must, at a minimum, include one member jointly nominated by NHS trusts and NHS foundation trusts that, as I have alluded to, require services in the area; one member jointly nominated by persons who provide primary medical services within that area; and one member jointly nominated by the local authorities within the ICB area.

12.30 pm

Requiring those ordinary members to be nominated from their own sectors will ensure that ICBs have a strong sense of shared ownership. It will also ensure that the board has local credibility and legitimacy. I must emphasise, as I have done throughout the passage of the Bill thus far, that the membership requirements set out in this clause are only the statutory minimum. We expect ICBs to use the flexibility that this schedule provides to go further in ensuring the inclusion of a wide range of voices across health and care in decision making. We have taken this approach because we want local areas, by agreement, to decide for themselves who is best placed to sit on their board—indeed that was a key recommendation of the NHS.

As clause 13, concerning establishment of ICBs, makes clear, NHS England will be responsible for approving proposed ICB constitutions. As I have emphasised, any revisions to ICB constitutions will also require NHS England's approval, and NHS England will have the power to vary an ICB's constitution on its own initiative. We will work with NHS England to ensure that they will not approve any constitution that fails to demonstrate that the ICB will draw on a wide range of relevant expertise when making decisions.

Alongside membership, this schedule requires ICB constitutions to specify how the ICB plans to discharge its functions, including through committees and sub-committees. In line with our wider approach, we have not specified in legislation the local, place-based structures that must be established. This is because we want local areas, by agreement, to be able to design decision-making structures that work best for them, focusing on the permissive rather than the prescriptive in legislation. Variation across the country in the footprint, composition and role of place-based partnerships means that an inflexible approach to place governance would be unhelpful and risk undoing the progress already made towards joint working. Indeed, it will be important to preserve place-based decision making where this is already working well.

Finally, the schedule requires ICBs to include critical information about how they will meet their statutory duties to deal with conflicts of interest efficiently and effectively, and how they will involve the public transparently in decision making.

Part 2 of the schedule sets out further operational detail and information relating to the functioning of ICBs. This includes details concerning the legal status of an ICB and its ability to employ staff or arrange staff secondments. The provision relating to staff terms and conditions remains in line with the provisions for other NHS bodies. It also places requirements on ICBs regarding financial arrangements and record keeping, as well as conferring powers to make payments of allowances to members of committees or sub-committees, enter into legal or financial agreements and acquire and dispose of property.

The schedule confers all the necessary powers and requirements to enable the ICB to discharge its general functions. I hope that the Committee will agree that it is therefore crucial to the establishment of ICBs and will ensure consistency in the arrangements across England. I therefore commend the schedule to the Committee.

Justin Madders: We will not divide the Committee on the schedule but as we have batted quite a lot of this about for a couple of days, it is worth reiterating some of our concerns in relation to how ICBs will actually work in practice.

Taking the Committee through the schedule, in paragraph 4 we have concerns about the chair having to be approved by the Secretary of State and, indeed, under paragraph 5 the chair can be removed by the Secretary of State, which could create tensions and speaks to the reality of how much autonomy these bodies will have. Paragraph 6(2) states:

"constitution must provide that a person is eligible to become or remain the chief executive only if the person is an employee of the integrated care board."

That stands to reason, but the interim guidance on ICBs for the position of chief executive says that they must be employed or seconded to the ICB. Indeed, the chief finance officer, the director of nursing and the medical director can all be employed or seconded to the ICB, according to that guidance. We think that potentially represents a conflict of interest. It needs clarification, because what is in the Bill does not necessarily sit well with what is in the interim guidance. I wonder whether the Minister can clarify that.

Paragraph 7(1)(a) of the schedule talks about the constitution specifying who should be appointed as ordinary members. Again, the interim guidance helps in providing a list of suggestions regarding ordinary members. It is worth pointing out that, when we totted up all the people the guidance says are the minimum requirement for a board, it comes to 10 people. Although the Bill may say three, the reality is that the guidance says many more. Again, that speaks to the amendment that we tabled on Tuesday about the numbers on the board. The idea that the Bill is permissive is slightly betrayed by the detailed guidance. It depends on what is meant by "permissive".

One particular mystery is in paragraph 7(3), which says:

"The constitution must set out the process for nominating the ordinary members".

We know that ICBs will be able to set their own constitutions, approved by NHS England, but how the particular individuals on the boards will emerge still feels rather opaque. Of course, we hope that such things can be done by consensus and agreement. No doubt in the majority of cases they will be, but given the size of some of the areas it will be very difficult sometimes to get a geographical spread that represents the whole area and the various interest groups that constitute an ICB. Of course, diversity may also struggle to be accommodated within that. Such things are all fine and good in the Bill and in the guidance, but I think delivery on the ground will be slightly more difficult to achieve.

Paragraph 8 talks about qualification and tenure for membership of the board. I would be interested to hear the Minister's comments on whether there is an optimal period of membership of a board. I think I saw two years somewhere in the guidance. I may be mistaken on that, but that seems a little short to me. I wonder whether he has a particular view on that. Paragraph 9 talks about constitutions being required to comply with any regulations that may come forward. Of course, the Bill has a lot of such clauses, where regulations will be produced in due course. I know this is slightly out of his control, but the Bill may not come back to us until much later in the year, if at all this year, depending on how the other place views it. That may mean that we are really down to the wire in terms of any enabling regulations that are needed under the Bill.

Paragraph 10 deals with the terms and conditions—a point that we discussed this morning. Paragraph 14 is quite interesting, because it talks about variation of the constitution, and how that should be done in consultation with NHS England. Indeed, NHS England will retain its own power to vary the constitution. It is important to put on the record that if such steps are taken to change the constitution, it is really important to involve stakeholders, the public, patients and workforce representatives. I hope that the Minister can fill me in on some of the details.

Edward Argar: I will try to address each of the shadow Minister's points one by one, perhaps not in an entirely fluent way.

The hon. Gentleman asked about what he perceived to be an inconsistency between interim guidance and what is proposed in terms of secondees in similar employment. Actually, under paragraph 18(4) of schedule 2, the legislation allows for secondments to continue for those employed as chief executives. It specifies particular organisations, such as secondments from trusts, other parts of the NHS, such as NHS England, or indeed from the civil service. Given that specification, I do not believe that there is an inconsistency.

The hon. Gentleman touched on interim guidance and how that fits with what the Bill will look like once it is, as I hope, enacted. I would gently remind him that it is interim guidance—the key word being "interim"—to allow the continued evolution of ICSs at the moment, without pre-judging what the House may or may not do in terms of making them statutory. That guidance is there to allow them to continue on their path without having to sit and wait for the deliberations of the House on something that they are empowered to do and are already doing. I do not necessarily see the opacity to which the hon. Gentleman alludes but he may disagree.

The hon. Gentleman spoke about geography and the number of local authorities and other organisations involved. I suspect that he has got in mind his own particular geography of Cheshire and Merseyside and the size of the ICS there. That goes to the heart of why we are being permissive: we are setting out a minimum level, and therefore there is nothing to stop an ICS of that size, if it so chose, at ICB level to have a broader range of people sitting on it and a larger number. Each organisation will be able to judge what it thinks is the appropriate number of people to sit on its board to reflect the need for effective decision-making and effective local and organisational representation to reflect the broad geography of its remit.

The hon. Gentleman also asked about the optimal length of service on a board. I have to say in my experience, and I suspect in his from his days in local government, one sees a multitude of approaches in different public bodies. Some tenures are for two years or three years, or two years with a renewal presumed for another two years. I am not sure that there is a clear one size fits all, but there should be principles underpinning it, namely that one does not have someone who joins and never leaves the board, and one has to have the ability to refresh the board to bring in new skills. From my experience of sitting on various boards, including charity boards as a trustee or as a non-executive director, effective organisations need to conduct regular skills audits of their boards, to ask what has changed and what the organisation is lacking in the modern world. As time goes by, one needs different skills and different mixes of people. I would expect ICBs and ICPs to continue to look at what is needed to be at their most effective.

I hope that I have broadly addressed the main thrust of the hon. Gentleman's points. The other points were those that he has quite rightly come back to, and which we debated at length when we considered his other amendments and those tabled by the hon. Member for Bristol South. On that basis, I encourage members of the Committee to support the schedule.

Question put and agreed to.

Schedule 2 accordingly agreed to.

Clause 14

PEOPLE FOR WHOM INTEGRATED CARE BOARDS HAVE RESPONSIBILITY

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

12.45 pm

Edward Argar: The clause requires NHS England to publish rules setting out which people each ICB is responsible for. We intend to recreate as closely as possible the arrangements that currently exist for clinical commissioning groups. However, CCG responsibility is based on a model of GP membership that will no longer exist under the new ICB arrangements.

The clause places a duty on NHS England to publish rules determining the responsibility of each ICB, subject to certain exceptions that may be created by secondary legislation. This is intended to replicate the ability to make exceptions to the responsibilities of CCGs by regulations in section 3(1D) of the National Health Service Act 2006. As with the existing regulations, the new regulations would be subject to the affirmative procedure of the House, which I hope offers some reassurance to the Opposition Front Bench in respect of the regulation-making powers. Therefore, there would continue to be strong parliamentary oversight of regulations under the clause.

Proposed new section 14Z31 ensures that no one slips through any gaps. The rules set by NHS England must ensure that everyone who accesses primary medical services, as well as anyone who is not registered with a GP but is resident in England, is allocated to a group of people for which an ICB is responsible. In practice, we expect NHS England's rules to be framed in such a way that ICBs will be associated with certain GP practices, and responsible for patients registered with those specified GP practices. They will also be responsible for people who are not registered but are resident in the ICB geographical footprint.

Taking that approach is intended to ensure universality of coverage and to minimise the disruption of transitioning from CCGs to ICBs. The clause also provides a power to replace the duty on NHS England to publish rules dealing with ICB responsibility, with an alternative approach based simply on residency. If it is considered appropriate in the future, those new arrangements would mean that ICBs were responsible for those who usually reside within their specified geographical footprint. Regulations would be required in order to change that approach.

The clause provides the necessary certainty about which ICB is responsible for which people. Without it, there could be significant confusion about ICB responsibilities, difficulty in calculating financial allocations to ICBs based on those they are responsible for and uncertainty for providers about which people they are contracted to provide services to. The clause seeks to provide fluent continuity with the arrangements under CCGs, and explicitly does not allow people to fall through gaps. Ultimately, everyone will be the responsibility of an ICB and will be able to access care when they need it. I therefore commend the clause to the Committee.

Justin Madders: I will make some comments on clause 14. I think the Minister has anticipated to some extent what I might say. I may well drift into clause 15 as well, but I

[Justin Madders]

promise the Committee that I will not repeat those comments in the discussion on clause 15. There is clearly an overlap here. It really is about the issue that the Minister referred to: who is entitled to what within the comprehensive NHS? For some, this is a formality, repeating the language used before and the principles on which the NHS was founded. For others, every word change and new clause that appears in the legislation is an attempt to restrict access and allow an opening for cuts to services to be made in a time of immense financial pressure. We want, and I think the Minister has opened the door to this, to ensure that that is not what the Bill is about.

To be fair, there is a history of commissioners trying on occasions to restrict access. There was the Croydon list of some 20 years ago. Primary care trusts set out lists of services and said that the treatments had little or no value and should not be provided on the NHS. Of course, that led to huge debates between trusts and medical practitioners. It could be argued that people were defending their own particular practices and specialties, or they could be said to be champions of the NHS. Patients looked at it from both perspectives, but for the patients who relied on those services it was a very real debate and a very real source of anxiety.

A more recent argument on this came from the various attempts to apply NHS charges to certain people who it was argued were not eligible for free treatment. There is a very sinister echo of the phrase "no access to benefits". The long-held consensus appeared to be under threat—the principle that emergency NHS care is open to all. When American tourists come over here and have to seek emergency treatment they are pleasantly surprised, and somewhat bemused, that they do not have to produce a credit card at the point of use. This is where the arguments begin to arise.

If a patient is moved from an emergency bed for elective care, they can be charged if they are ineligible for free NHS care. The usual test is whether they are ordinarily resident in the country. On principle, if someone qualifies for NHS treatment, they can get it anywhere in the country, while on holiday. Most of us have taken our breaks this year somewhere in this country. We do not have to go back to our own local A&E to get treatment. We could, in theory, get our elective operations anywhere in the country, should we wish. Pre-Lansley this did not matter as much, because it was always payment by results. Ambulances crossing borders may occasionally result in a cross-organisational internal charge. Maybe we will see an end to that kind of bureaucracy.

The other argument that emerged during the Lansley period was around who the responsible commissioner within a particular area or population was. That market approach required tying people to a GP practice. The GP register has been a central base from which decisions were made. Did that really affect things on the ground? It certainly caused a lot of debate. It would be helpful if the Minister provided clarity.

The issue of access is important, and clause 14 sets it out in subsections (1), (2)(a) and (2)(b) of proposed new section 14Z31 of the National Health Service Act 2006. According to the NHS, access is universal, but depending on their immigration status within the UK, a person may be charged for accessing certain services. However, certain services are free to everyone: treatment given in an A&E department, though this does not include further treatment following admission to hospital; treatment for certain infectious diseases, but for HIV/AIDS only the first diagnosis and counselling that follow are free; compulsory psychiatric treatment; and family planning services, but this does not include termination of pregnancy or infertility treatments. People ordinarily resident in the UK or who have an exemption from charging will not be charged for NHS treatment. I could go into what ordinarily resident means, but I will not detain the Committee by going through all of that. However, it is fairly clear that it can be a British citizen or someone naturalised or settled in the UK, usually known as having indefinite leave to remain.

The Bill does not cover any of this, but there is a point about it not necessarily being the same person paying for and receiving the treatment. There are questions about those seeking asylum and those who might be denied care because there are questions about where they live. There was the image of a paramedic stepping out of an ambulance and asking someone suffering a cardiac arrest whether they had some kind of identification to prove that they were ordinarily resident. The images are not common ones, but they raise concerns. When the 2012 Act was debated, these issues were discussed at great length. I do not think the fears that were expressed at the time have manifested themselves. Does the Minister believe that using "usually resident" is better than "ordinarily resident"? I also wonder whether under proposed new section 14Z31, the NHS will publish rules as referred to. Could we have clarification on that?

Edward Argar: I will respond very briefly. The shadow Minister raises two key bundles of points. I hope that I can reassure him that the approach adopted here is far from restricting access. It is designed to ensure that everyone has an ICB covering them, ensuring universality of coverage. Similarly, the clause does not alter in any way the ability of anyone to access emergency care when they need it, nor those ordinarily resident in the UK to use the NHS as they do.

The second bundle of points he made related to charging regulations and those who are eligible to be charged under current regulations. While he highlighted a number of points, I genuinely believe that the charging regulations in place are appropriately and reasonably framed and strike the right balance in ensuring that people can access NHS care, while rightly making a contribution to the services they are accessing—obviously with certain things exempt from charging for public health and other reasons. I do believe they strike the appropriate balance. There is nothing in what we are proposing today that fundamentally changes people's ability to access healthcare, nor indeed changes those charging regulations. On that basis, I commend clause 14 to the Committee.

Question put and agreed to.

Clause 14 accordingly ordered to stand part of the Bill.

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

12.56 pm

Adjourned till this day at Two o'clock.