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Public Bill Committee

HEALTH AND CARE BILL

Fifth Sitting

Tuesday 14 September 2021

(Morning)

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Saturday 18 September 2021

The Committee consisted of the following Members:

Chairs: Steve McCabe, † Mrs Sheryll Murray

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

Huw Yardley, Sarah Ioannou, *Committee Clerks*

† attended the Committee

Public Bill Committee

Tuesday 14 September 2021

(Morning)

[Mrs Sheryll Murray *in the Chair*]

Health and Care Bill

9.25 am

The Chair: Before we begin, I have a few preliminary reminders for the Committee. Please switch electronic devices to silent. No food or drink is permitted during sittings of the Committee, except for the water provided. I encourage Members to wear masks when they are not speaking, in line with the current Government guidance and that of the House of Commons Commission. Please also give each other and members of staff space when sitting and when entering and leaving the room. *Hansard* colleagues will be grateful if Members could email their speaking notes to hansardnotes@parliament.uk.

We now begin line-by-line consideration of the Bill. The selection list for today's sitting is available in the room. That shows how the selected amendments have been grouped together for today. Amendments grouped together are generally on the same or a similar issue. Please note that decisions on amendments take place not in the order they are debated but in the order they appear on the amendment paper. The selection and grouping list shows the order of debate. Decisions on each amendment are taken when we come to the clause to which the amendment relates. Decisions on new clauses will be taken once we have completed consideration of the existing clauses of the Bill. Members wishing to press a grouped amendment or a new clause to a Division should indicate when speaking to it that they wish to do so.

Clause 1

NHS Commissioning Board renamed NHS England

Justin Madders (Ellesmere Port and Neston) (Lab): I beg to move amendment 18, in clause 1, page 1, line 5, at end insert—

"(1A) The Board of NHS England shall be made up of—

(a) a Chair appointed by the Secretary of State,

(b) five other members so appointed of which—

(i) one shall be appointed to represent Directors of Public Health,

(ii) one shall be appointed to represent the Local Government Association,

(iii) one shall be appointed to represent the interest of patients,

(iv) one shall be appointed to represent the staff employed in the NHS, and

(v) one shall be appointed to represent the Integrated Care Partnership.

(c) one further member shall be appointed by the Secretary of State after being recommended by the Health Committee as a person with appropriate knowledge and experience,

(d) executive members as set out in Schedule 1 of the Health and Social Care Act 2012.

(1B) In making the appointments in (1A) (a) and (b) above the Secretary of State must have due regard to—

(a) the need to ensure diversity and equality of opportunity and must publish a list of at least 5 persons considered for each appointment and the reasons why the particular individual appointment was made, and

(b) that no person who could be perceived to have a conflict of interest by virtue of their current or recent employment or investment holding in any organisation with any role in the delivery of services to the NHS may be considered for appointment."

This amendment changes the makeup of the Board to acknowledge its new role in the integrated NHS and bringing representatives as non-executive members on the Board as with integrated care boards.

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

Clause stand part.

That schedule 1 be the First schedule to the Bill.

Justin Madders: It is a pleasure to serve under your chairmanship today, Mrs Murray, and to serve on the Bill Committee.

The amendment was moved in my name and that of my hon. Friends. The Minister whom I shadow is helpful—we will see how helpful during the course of proceedings—and we start in a spirit of optimism. I am grateful for the support of my colleagues on the Opposition Benches who, between them, contribute some relevant and highly knowledgeable experience. They are all passionate, as we all are, about the national health service and the care system, which are the subject of the legislation.

With your indulgence, Mrs Murray, I take this opportunity to make a few short points about the general context of the legislation. First, this is an important Bill. It could easily have been two or three pieces of separate legislation, so it requires proper consideration. We have a concern about whether enough time has been allocated to deal with everything in the detail that we would like, but we will do our best to get through it. We intend to make our contributions short but relevant and, we hope, persuasive.

Secondly, we share the apparent desire of the Government to repeal the worst aspects of the disastrous Lansley Act. Many of our amendments will be directed at trying to ensure that, in doing so, the baby is not thrown out with the bathwater. Thirdly and finally, as stated by the chair of the British Medical Association in the evidence sessions last week, we remain of the view that the Bill is the wrong Bill at the wrong time.

The amendment seeks to define the composition of the board of NHS England to align better with what we see as the new requirements set out elsewhere in the Bill. In looking at the issue of who should be on the board, we all ought to agree that it should not be open only to the friends and relatives of Ministers. Board members in our view should be subject to more independent assessment of their value and must pass at least some fit and proper test to avoid obvious conflicts of interest.

The amendment would ensure that the key influences on the board come from public health, local government, the patients themselves and the staff, without whom the NHS does not exist. At this point, I take the opportunity to place on the record, as I often do, Labour Members'

thanks to those in the NHS who have been so magnificent, not just over the past couple of years but over many years. They deliver a service that is rightly a source of great national pride. They deserve a seat at the table, as do patients. The Bill does not do enough to amplify the patients' voice. We will be discussing a number of amendments over the coming weeks by which we will hope to change that.

We also need to look at what NHS England mark 4 will be required to do if the Bill becomes an Act. Other parts of the Bill deal with the powers and duties of this new version of NHS England, originally the NHS Commissioning Board. It is, in many ways, the pinnacle of the reversal of the Lansley position. The new NHS England does not bear much resemblance to what was envisaged under the Health and Social Care Act 2012. That is a good start, but one aspect of the Lansley view—that the NHS requires some degree of operational independence—has been shown to have some merit. Every clock is right at least twice a day, and we have found the one piece of the 2012 Act that proved to be correct. We will discuss some amendments later on to limit the power of Ministers to interfere with those who we believe should be operationally independent.

The new NHS England is pretty much in place anyway, as a result of the actions of those managing the NHS over the last few years. They desperately and very innovatively at times tried to find ways to circumvent the edicts of the 2012 Act, while Ministers looked on passively. It has been an unusual and interesting passage of time in the history of the NHS. We have seen legislation simply ignored and Ministers have allowed that to happen. It is little wonder, given the experiences of the 2012 Act, that many of the NHS witnesses we heard from said they wanted as little prescription as possible. They have had their fill of prescription. We would differ, I think, on the level of prescription necessary in the Bill.

New NHS England will be an amalgamation of the old NHS England, Monitor and the NHS Trust Development Authority. It will commission some specialist services. It will be the regulator, regulating a market that no longer exists. It will performance manage both commissioning by the integrated care boards, which, for the purpose of brevity, we will refer to as ICBs, and the provision of services by trusts and foundation trusts. I am afraid that how that wide range of responsibilities sits with the role of the Department is as vague as ever. The ability of Ministers and others to interfere and micromanage depends on whether the rest of the Bill survives in its current form.

Above all, the board oversees the operational running of the NHS, shaped by the mandate, which gives the direction of travel. Perhaps the most crucial policy change is that new NHS England sits at the top of the system, based on the integrated care boards as the major commissioner of services. That means who sits on the board is highly relevant.

The explanatory notes and the Government pronouncements about the new integrated bodies strongly assert that the role is to drive the reintegration of the NHS, repairing the worst of the fragmentation caused by Lansley and, I hope, once and for all, ending the obsession with marketisation, which has been shown to be a failure. We need board members on NHS England who might be seen to be more in tune with the new philosophy of partnerships and collaboration—not markets and competition, not business leaders, hedge fund managers, marketing experts.

In the new world, we want the NHS to be bound by its core principles—comprehensive, universal, free and funded from general taxation. That is a topic that we may touch on later; it may also be discussed in other business of the House today. What should be valued in board members is that they have some record of commitment to those principles. They should have some claim to be aligned to the new values, which favour a stronger role for patients; the public to have influence; a view that the NHS is contributing to reducing inequalities, as well as improving wellbeing; and the greater alignment of NHS services with local government.

The current make-up of the board is, put simply, the chair plus five other non-executives, all appointed by the Secretary of State, and then of course the appropriate executive directors. This amendment deals only with the non-executive directors. Given the huge importance of the NHS, it is appropriate that the chair and at least some of the non-executive directors are appointed by the Secretary of State. We will concede that. In another world, perhaps they could be elected in their own right, but we will not be travelling down that road on this occasion. However, we cannot ignore some of the headlines over the last 18 months and the huge media coverage of quite blatant abuse of patronage in appointments in the NHS more generally in recent years. Cronyism, I am afraid to say, has become a default position, and we think that has to be challenged.

To be fair to past Ministers, the NHS itself can also appoint people for the wrong reasons, moving out disgraced leaders if they go quietly, only for them to re-emerge somewhere else in the system. If the NHS is an organisation—it is a stretch to use that term after the mess created by the 2012 Act—appointments should accord with the highest standards of fairness, and inclusion is notably absent, so let us change the approach. Let us set the tone from the very top and enshrine in law the kind of people whom we as a Parliament would like to see—not, of course, specifying individuals but setting out in general terms some of the main interest groups that contribute towards the NHS and that we think should be at the very top table.

The amendment therefore seeks to give some direction to the Secretary of State in making these appointments and to ensure that at least one non-executive director is put on the board through a genuinely independent process and is not simply placed there by the Secretary of State. The kind of representative appointments that we set out in the amendment should, in our opinion, really be the standard. We would hope to see a similar standard adopted for the ICBs. We should appoint people who can really contribute to the future, with direct experience across the board in terms of the integration that the Bill seeks to achieve. The amendment also sets out how the Secretary of State must appoint suitable people and be able to justify their appointments against some sort of standards.

I hope that the Minister will at least acknowledge that some of the recent questionable behaviour around appointments needs to be addressed. No doubt he will refute the allegation of cronyism, but he cannot deny that there is at least a very strong perception that that is what has happened with some appointments.

[Justin Madders]

In conclusion, I draw attention to how the NHS has already, effectively, blatantly put up two fingers to this Committee and anything we might decide, because it has already decided for itself how it will appoint people to roles within the new integrated care boards and has appointed some already, with the remaining positions, as we have seen from newspaper headlines, up for advertisement. That does not actually do us any favours, because Parliament has not decided that that is what we want to do, but we will see whether we get to that point later. That is all I have to say on the amendment.

The Minister for Health (Edward Argar): It is a pleasure, once again, to serve under your chairmanship, Mrs Murray. I fear—predict—that there will be occasions when the shadow Minister, the hon. Member for Ellesmere Port and Neston, and I may not be entirely of the same mind, but it is a pleasure, as always, to serve opposite him on this Committee, because I know that even where we may disagree, the debate will be measured and reasonable. I will address the amendment tabled by the shadow Minister and, in the same speech, clause 1 and schedule 1 stand part if that is appropriate and in order.

As has been the practice on numerous occasions in these Committees, I will start by expressing a view shared by all members of this Committee. It has already been expressed by the hon. Member for Ellesmere Port and Neston, and we join with him in expressing our gratitude to those who work in our NHS and in care services and—as he and I have often said in this place—all those, including in local government, who work in this space and have done amazing work over the past year and a half particularly.

As ever, the hon. Gentleman picked his example carefully in citing some of the witnesses whom we heard in oral evidence. As he will know, the overwhelming majority—possibly with only two exceptions—stated that this was the right Bill at the right time, albeit they may have picked up on particular clauses or elements. They did state that this was the right time for this legislation.

As the shadow Minister has set out, amendment 18 in his name and those of his hon. Friends seeks to make changes to the make-up of the board of NHS England, the provisions for which are currently set out in schedule A1 of the National Health Service Act 2006. It also outlines conditions that should be met in relation to the appointment process. I share his view that it is vital that robust governance arrangements are in place for overseeing public appointments. It will not surprise him that I refute his assertion that in the case of NHS England board appointments there is a so-called cronyism or a suggestion that any of those people are appointed on anything other than merit. However, I believe that those strong and robust governance arrangements are already in place for managing appointments to the board of NHS England. Those appointed already are deemed to be fit and proper people to hold those appointments.

The existing provisions, which the shadow Minister alluded to, setting out the membership of the NHS England board in the National Health Service Act 2006, provide the flexibility required for the fully merged NHS England to lead our more integrated health and care system. The clauses we will be addressing this morning in this part of the Bill reflect the evolution of NHS England and NHS Improvement and what has happened on the ground since they were originally formed. With this, we seek to create a legislative framework that catches up with where they are and is permissive, rather than prescriptive. That is something else the hon. Gentleman and other members of the Committee will have seen from the evidence sessions. Witnesses were clear that the Bill struck the right balance between permissive and prescriptive.

As we look to continue the fight against the covid-19 pandemic and, in parallel, prepare for the recovery of our health and care system, it is imperative that the most suitably experienced and knowledgeable candidates are appointed to the Board. I know the shadow Minister will share that sentiment. Unlike appointments to integrated care boards, the appointment of the chair and non-executive members of NHS England are rightfully public appointments made by the Secretary of State and managed in line with the governance code for public appointments and regulated already by the Commissioner for Public Appointments. The appointments are made on merit in a fair, open and transparent manner and in line with that governance code. They also require due regard to ensuring they properly reflect the populations they serve, including a balance of skills and backgrounds, supporting the Government agenda of promoting more diverse public sector organisations and board appointments.

The role of non-executives on public bodies includes helping set the strategic direction for the organisation, ensuring the organisation meets the highest standards of good governance and holding the executive to account for day-to-day business delivery. They come from a variety of backgrounds and bring a valuable range of skills and experience to a board position. It is important to note that they are not routinely or normally appointed to be representative of a particular sector or group. They are on the board in their own right and their independence in that context is paramount.

All public appointees are expected to uphold the standards of conduct set out in the Committee on Standards in Public Life's seven principles of public life, as included in the code of conduct for board members of public bodies, and they must adhere to that. The code sets out clearly and openly the standards expected from those who serve on the boards of UK public bodies and includes a clear process for managing any conflicts of interest. The Commissioner for Public Appointments regulates those appointments to ensure they are upholding the values of that Government code and works with Government to encourage candidates from a diverse range of backgrounds to consider applying for such public appointments.

Finally, while I share the shadow Minister's view that it is hugely important to have diverse representation on the board of NHS England and to ensure that diverse voices and viewpoints are reflected, the duty under section 13H of the 2006 Act already requires NHS England to actively

"promote the involvement of patients, and their carers and representatives"

without the specific need for a named non-executive patient representative. It is clear that comprehensive processes and codes are already in place to regulate public appointments such as those we are discussing in the context of clause 1 and amendment 18, as well as

schedule 1, including on diversity, conflicts of interest and conduct in office. I emphasise once again that the role of non-executive members is not that of representing a specific or particular sector, which could be at odds with the independent and broad approach they are required to bring to the role.

I now move specifically and briefly to clause 1, which changes the legal name of the NHS Commissioning Board to NHS England, and also to schedule 1, which contains consequential amendments where the changes will take effect in another Act. Since 2013, the NHS Commissioning Board has been operating under the name NHS England, and I think it is fair to say that that is how all of us in this room, and the public, know it, rather than by the slightly clumsy name of NHS Commissioning Board. This move reflects what the public already regard as the body's name. The organisation, including the new functions provided to it by the Bill, will continue to operate under the name NHS England; this clause aligns the legal and technical name with the operational and publicly used name for clarity, and updates associated primary legislation.

9.45 am

The clause puts in statute that legal name change. NHS England is an organisation that patients, public and staff recognise as providing leadership to the system and sector. It has been at the forefront, with each and every one of those who work in the NHS, of supporting operational delivery during the covid-19 pandemic and the integration of systems across the health and social care sectors. I believe it is right, as we update the governance arrangements for NHS England, that we make provision for this name change in legislation to provide legal clarity. I urge the shadow Minister to consider withdrawing his amendment, and I urge colleagues to support clause 1 and schedule 1.

Justin Madders: I am grateful for the Minister's response, although disappointed that he does not agree with my amendment; I fear that may be a regular experience over the next few weeks, but we will carry on in hope rather than expectation.

As a final response, I would like to reflect on the kind of people we currently have on the board of NHS England. This is not meant to be a criticism of them at all—they are all very experienced and talented people—but their experience is not in healthcare; it is mainly in things such as retail or finance. They clearly have great qualities, but if hon. Members look at what is in our amendment and the kind of people we say ought to be at the top table, it is clear from the past 18 months how critical a role those people play.

Take, for example, the directors of public health. They have been the unsung heroes of the pandemic. I certainly know my local director of public health much better now than I did at the start of 2020, and he has been absolutely magnificent. He has always been available and, along with just about everyone else in the public sector, the amount of work that he has put in is phenomenal. That breadth of knowledge and experience deserves a seat at the top table.

Similarly, there should be a representative of the Local Government Association. Obviously there is some overlap with directors of public health, but local government has been magnificent, as the Minister noted, during the pandemic. We know that the vaccine roll-out, for example, and the ability to dispense tests quickly have been down to the agility of local authorities working in partnership with the NHS and the voluntary community sector.

There should also be a representative for patients; it seems a little odd that their voice is not at the top table, and I say the same about a representative for the staff. We talk a lot in here about how much we value the efforts of the staff, but we should put that into practice by acknowledging that they deserve a voice at the top table.

Clearly, the Minister will not accept the amendment, so I will seek to withdraw it, but I think we have made our point clearly about the kind of people we think should have a say in how NHS England is run. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Clause 1 ordered to stand part of the Bill.

Schedule 1 agreed to.

Clause 2

Power to require commissioning of specialised services

Justin Madders: I beg to move amendment 36, in clause 2, page 1, line 9, at end insert—

"(1A) In subsection (1), leave out "it" and insert "the Secretary of State"."

This amendment, with Amendment 37, NC20 and NC21, restores the duty on the Secretary of State to provide or secure the provision of services to that in the National Health Service Act 2006.

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

Amendment 37, in clause 15, page 13, line 18, leave out "it" and insert "the Secretary of State".

This amendment, with Amendment 36, NC20 and NC21, restores the duty on the Secretary of State to provide or secure the provision of services to that in the National Health Service Act 2006.

New clause 20—*Secretary of State's duty to promote health service*—

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

(2) For section 1 (Secretary of State's duty to promote comprehensive health service) substitute the following—

"Secretary of State's duty to promote health service

(1) The Secretary of State must continue the promotion in England of a comprehensive health service designed to secure improvement—

(a) in the physical and mental health of the people of England, and

(b) in the prevention, diagnosis and treatment of illness.

(2) The Secretary of State must for that purpose provide or secure the provision of services in accordance with this Act.

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

This new clause would restore the wording of section 1 of the NHS Act 2006, concerning the duties of the Secretary of State regarding the promotion of the health service, to its original form, before it was amended by section 1 of the Health and Social Care Act 2012.

[The Chair]

New clause 21—*Duties on the Secretary of State to provide services—*

"(1) The Secretary of State must provide, in England, to such extent as he considers necessary to meet all reasonable requirements—

(a) hospital accommodation,

(b) other accommodation for the purpose of any service provided under this Act,

(c) medical, dental, ophthalmic, nursing and ambulance services,

(d) such other services or facilities for the care of pregnant women, women who are breastfeeding and young children as he considers are appropriate as part of the health service,

(e) such other services or facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as he considers are appropriate as part of the health service,

(f) such other services or facilities as are required for the diagnosis and treatment of illness.

(2) For the purposes of the duty in subsection (1), services provided under—

(a) section 82A (primary medical services), section 98C (primary dental services) or section 114C (primary ophthalmic services), of the NHS Act 2006, and

(b) a general medical services contract, a general dental services contract or a general ophthalmic services contract,

must be regarded as provided by the Secretary of State."

Justin Madders: These amendments and new clauses are significant because, if accepted, they will put an end to the seemingly endless arguments that we saw during the passage of the 2011 Health and Social Care Bill. There is a whole shelf of books pointing out the changes in wording in what became the Health and Social Care Act 2012, and how they marked the end of the NHS as we previously knew and understood it. Allegedly expert barristers—although I have never met a barrister who did not claim to be an expert in something—wrote articles about how that new wording changed everything. On the other hand, the Government explained that they had changed nothing, and had simply put the reality on the ground into words.

David Lock QC, a genuine expert on NHS law, said that this technical change attracted considerable and possibly misguided criticism, but it did not involve any substantial change in practice. However, as reported by the noble Lords, it caused considerable confusion and suspicion. This confusion revolves around what is included in the NHS; what defines the comprehensive NHS; and how services required for the NHS are to be provided. Over time, the NHS has had many different structural solutions for providing these services, and indeed we are on yet another iteration of such a solution—we will see how long this one lasts.

The debate on that change of wording took up days of the Public Bill Committee's time—or, should I say, the first of those Committees, as they had two goes at it on the last occasion. Let us hope we do not suffer a similar fate. Following that, there were hours of debate in the other place. The issue was then considered by the Constitution Committee, and some sort of compromise emerged, with insertion into the 2012 Act of what became, in the end, section 1(3) of the National Health Service Act 2006, as amended, which said:

"The Secretary of State retains ministerial responsibility to Parliament for the provision of the health service in England"—

we hope that that is always the political reality, no matter the wording used in the legislation.

The extra wording proposed in new clause 20 sits within section 1 of the 2006 Act, and states:

"The Secretary of State must continue the promotion in England of a comprehensive health service designed to secure improvement—

(a) in the physical and mental health of the people of England, and

(b) in the prevention, diagnosis and treatment of illness."

I will not read out the whole amendment, but I want to compare that section of the wording with that of the founding National Health Service Act 1946, which says:

"it shall be the duty of the Minister of Health to promote the establishment of a comprehensive health service designed to secure improvement in the physical and mental health of the people…and the prevention, diagnosis and treatment of illness, and for that purpose to provide or secure the effective provision of services".

We have this curious word "promote". To my mind, promoting puts a positive onus on the Secretary of State, but if he has a duty to promote a comprehensive NHS, how exactly should he do that? In 1948, did Nye Bevan drive up and down the street with a megaphone, urging people to go and see their doctor? Today, it would probably mean the Secretary of State sending out a tweet to do the same—although, given what we hear about GPs' workloads, they would not thank the Secretary of State for that. Or does this duty mean that when we are in the Chamber, and some rogue Member claims that we should abandon the NHS and move to some kind of insurance-based model, the Secretary of State should leap up and promote away?

Over the past few years, even before covid, we have seen more and more people going for private treatment because waiting lists are so long. We know that whatever is decided in the legislation in the main Chamber today, those waiting lists are not going to reduce significantly for some considerable time. Is it in fact the case that the Secretary of State is not complying with his duty to promote the NHS by allowing these waiting lists to grow and grow, thereby forcing people to secure alternative provision? The word "promote" can have multiple meanings, and I can think of a few Secretaries of State who have lamentably failed to promote the NHS, and should probably not have been promoted in the first place.

The contentious bit of this issue is really about what makes up the NHS. It was claimed about the Lansley Bill, and has been claimed about this Bill, that the change in wording implies that people would be denied access to treatment from the NHS because, for example, an ICB decides to exclude a particular service, and there is no duty on the Secretary of State to stop that happening. A few points are clear enough: the Secretary of State promotes the comprehensive NHS, but does not provide it. The boundaries of what the NHS actually is change over time, as we all know. Social care is now outside the NHS, although that will probably alter slightly over the next few years. The National Institute for Health and Care Excellence can redefine the boundaries; primary care trusts and clinical commissioning groups could exclude treatments on a whole range of different criteria that, while they may not have admitted it, did amount to an exclusion; and of course, advances in medical science mean that many things that were not available

in 1946 and, indeed, could not possibly have been conceived of during the original Act, are available now on the NHS. Those boundaries are never entirely clear, and it is often up to the courts to draw out a decision about what healthcare amounts to.

However, in the 2006 Act, there was at least a bit of definition in clause 3:

"The Secretary of State must provide throughout England, to such extent as he considers necessary to meet all reasonable requirements—

(a) hospital accommodation,

(b) other accommodation for the purpose of any service provided under this Act,

(c) medical, dental, ophthalmic, nursing and ambulance services,

(d) such other services or facilities for the care of pregnant women, women who are breastfeeding and young children as he considers are appropriate as part of the health service,

(e) such other services or facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as he considers are appropriate as part of the health service,

(f) such other services or facilities as are required for the diagnosis and treatment of illness."

I could go on, but I hope Members will take my word for it that this is very similar language to that of all the previous NHS Acts, going back to 1946. That is essentially what new clause 21 seeks to reassert and confirm for the purposes of clarity, so that where there are subordinate bodies such as PCTs, CCGs or even NHS England, those duties are very clearly set out at the top and can then percolate down.

Under the current Bill, the ICBs have a responsibility to provide services for a defined population that is phrased much like the above definition, but there is no duty on the Secretary of State to provide throughout England; in other words, there is nothing specific to say that the duty on the Secretary of State should be delegated to ICBs, which we say there should be. Our intention is to restore the position that the duty is placed on the Secretary of State, which he then delegates down to NHS England, ICBs and so on. We could spend a lot of time on this, as our predecessors have, but I do not think that will be the best use of our time, so we have attempted to avoid going down that particular rabbit hole with a straightforward amendment, with what I hope has been a straightforward explanation.

The Lansley changes were made to align with the NHS structures that the then Secretary of State introduced, which were essentially market structures, distancing the Secretary of State in the sense that they were unlike anything the NHS had done previously, which was part of the reason why there was so much debate about them. That is why in 2015, 2017 and 2019, we made it clear in my party's manifesto that we would reinstate the duty to promote and deliver the NHS, so there would be no doubt that it was a public service and could be restored to that footing. Our argument is that for simplicity, we should restore the duties to those of the pre-Lansley era, to reflect that the Lansley experiment has failed and we are in a new world—a new world with the old wording, which we wish to reinstate. Let us keep it simple, save everyone a lot of work and go back to the old wording, so that there is no doubt about where the duties and responsibilities lie.

10 am

Karin Smyth (Bristol South) (Lab): I support the words of my hon. Friend the Member for Ellesmere Port and Neston. The Government would be wise to take note of the proposal. As my hon. Friend said, many hours, days and weeks have been spent by not only Members of Parliament, but expensive lawyers and lots of concerned constituents across the country, arguing—as I have often thought myself at times—a slightly nuanced point, which is lost on people. I have absolutely been persuaded, however, that it is important to restore that duty. If the Government are rightly binning the Lansley Act, the amendment is an obvious one to consider and accept, as it puts the duty absolutely beyond doubt.

Running throughout the Bill, as we will discuss over the next few days and weeks, is a real problem of clarity and accountability. We should not let the Bill out of this place while it leaves that lack of clarity on duties, responsibilities and accountability for the NHS to decide, along with local government. There is a balance between permissiveness and diktat, and starting with clear duties on the Secretary of State would help. Later, we will discuss how the Government seem to want to give the Secretary of State enormous power to interfere in the most minute aspects of healthcare in our constituencies, something that concerns a great many people, organisations and the NHS itself.

If the Government are serious about rehabilitating themselves as the supporter of the NHS following the Lansley Act, an amendment to clarify that absolutely central role would be a wise thing to accept.

Edward Argar: Amendments 36 and 37 and new clauses 20 and 21 are in the name of the shadow Minister and his colleagues. I do not believe that what is being proposed reflects the reality of the role of the Secretary of State or what it should be, which is a strategic oversight role with the ability to intervene when necessary to ensure accountability. The hon. Gentleman might correct me, but I think he cited Mr Lock, who said that there was no substantial change in practice. That goes to the heart of why I am unpersuaded by the amendments.

As the hon. Gentleman knows, the idea that the Secretary of State himself provides services has not reflected the reality of the structure of the NHS for many years, not least since 2003-04 with the introduction by the Labour party when in government of foundation trusts as independent entities in the health system. That purchaser-provider split, long established in the NHS and retained in the Bill, allows some of the health services in England to be provided by those such as NHS foundation trusts, which are legally distinct from the Secretary of State.

In the years since those changes, and as the many vigorous debates in Parliament since and during the passage of the 2012 legislation have demonstrated, there has rightly been no loss in the strong sense of governmental accountability for the NHS felt by Governments of all parties and by parliamentarians. As the proposers of this group of amendments have themselves been among the most eloquent and capable colleagues in holding Ministers and Government to account for the NHS, I find it slightly strange that they feel that their amendment is necessary.

[Edward Argar]

At the time of the 2012 Act, as the shadow Minister alluded to, there was a great deal of debate in the other place on the value or otherwise of this wording. Eventually, the noble Lords concluded that it was better for the law to reflect the reality of the modern NHS. However, it remains the case that the Secretary of State has a firm duty to continue the promotion in England of a comprehensive health service in practice. He does this through setting the strategic direction and his oversight of NHS England and the other national bodies of the NHS, and in the future, subject to debates in this place—I do not want to prejudge what the Committee and the House may determine on those clauses—through the extra lever of the proposed power of direction. At all times, he remains responsible to Parliament for the provision of the health service in England.

NHS England also has a duty to arrange for the provision of services for the purpose of the health service in England and a concurrent duty to promote a comprehensive health service. Integrated care boards will, subject to parliamentary approval of the Bill, also have functions in relation to arranging the provision of services.

I understand the point that Opposition Members are seeking to make with the amendment, but it is entirely unnecessary as law. The Secretary of State has the duty to promote the competence of the health service in practice. He is accountable to Parliament for the comprehensive health service, and I believe that local NHS leaders and NHS England are best placed to know what is needed to serve individual communities.

This goes to the heart of what I suspect will come up a number of times in our debates in this Committee, which is the extent to which the legislation should be prescriptive, or permissive and flexible. I suspect the shadow Minister and I will disagree on where the balance should lie, in a number of areas. We believe that the Bill strikes an appropriate balance.

The shadow Minister talked about flexibility in redefining the boundaries of what the NHS does. Throughout the history of the NHS, there have been tweaks along those lines. The Labour party introduced charges for glasses and dentures; the Conservative party introduced charges for prescriptions shortly afterwards; the Labour party abolished them, and then reintroduced them two years later. I use those examples because I think we should be wary about being overly prescriptive in primary legislation.

Clause 2 makes a number of amendments to the power allowing the Secretary of State to require NHS England to commission certain prescribed services. It ensures that the Secretary of State can still require NHS England to commission specialised services and facilities, but recognises that aspects of the commissioning might be carried out by other NHS bodies through joint or delegated working arrangements or by directing integrated care boards to provide those services.

Specialist services are commissioned to support people with a range of complex and rare conditions. Those services could involve the treatment of patients with rare cancers, genetic disorders, and complex medical or surgical conditions, for example. As such, it is right that NHS England has overall responsibility for the services and can decide whether they might be better delivered through joint or delegated working arrangements or through directions to ICBs—I am happy to adopt the shadow Minister's suggested shorthand, otherwise we will be taking a very long time repeating the same words on multiple occasions.

The clause also removes the requirement of the Secretary of State to consider the financial implications for CCGs—to be replaced with ICBs—when requiring NHS England to commission certain services. The change focuses the decision about categorisation of specialised services on the complexity and impact of the service and the ability of ICBs to support commissioning services for their populations, reflecting the fact that ICBs are significantly larger than CCGs and, correspondingly, so are their financial resources. In some circumstances, NHS England may request that a service is no longer nominated as a specialised service or facility—that could be used, for example, as the technology improves and it becomes more appropriate for it to be commissioned by an ICB instead. The clause inserts a new provision in the NHS Act 2006 which requires the Secretary of State to provide reasons for any refusal to requests from NHS England to revoke provisions requiring NHS England to commission specialised services.

I therefore encourage the shadow Minister not to press his amendment to a vote.

Justin Madders: I am grateful for the Minister's comments, not least the promotion he inadvertently gave me by referring to me as shadow Secretary of State. We should have a Division on that, should we not? I understand what the Minister is saying, but our aim with this amendment is to reflect the new reality. No one has really got to the bottom of why the wording came out in 2012, but we are clearly moving back into a pre-Lansley era and the end of the marketisation, so we should go back to the previous wording. In terms of the services and duties in our new clause 21, I do not think the Minister said he disagreed that any of them should be provided. I am trying to do him a favour here and help him to avoid the Bill being bogged down in the Lords. If it comes back in ping-pong, we will quote the relevant new clause and say, "This is something that could have been avoided."

I understand that the Minister does not want to be too prescriptive. He is right that the Bill will centre largely on the right balance between permissiveness and prescriptiveness, and we will no doubt have disagreements on that. I have tried to be helpful to him, but he does not want to accept that assistance on this occasion, so I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Clause 2 ordered to stand part of the Bill.

Clause 3

NHS England mandate

Justin Madders: I beg to move amendment 19, in clause 3, page 2, line 12, leave out paragraph (e) and insert—

"(e) after subsection (6) insert—

'(6A) The Secretary of State may revise the mandate should urgent or other unforeseen circumstances arise.

(6B) If the Secretary of State revises the mandate, the Secretary of State must publish and lay before Parliament the mandate as revised with a written explanation of the urgent or other unforeseen circumstances that justify the revision and an impact assessment of the proposed change.'"

The Chair: With this it will be convenient to discuss amendment 20, in clause 3, page 2, line 30, at end insert—

"(6) No mandate may be laid before Parliament unless the Secretary of State has supplied a statement on how the mandate will be funded."

Justin Madders: These amendments to clause 3 deal with the mandate to NHS England. The mandate was part of the changes that were introduced to attempt to distance the role of Government and Ministers from the sound of the bedpans dropping. We can talk about how much the Secretary of State should be involved in that, but we will focus our comments on the mandate today.

What we saw was, in effect, an artificial distinction—one that, like so much else in the last piece of legislation, has largely been subverted or ignored. Despite the intentions, Ministers still try to micromanage and sometimes interfere, for what we would describe as political reasons, and the mandate has rumbled on. During the tortuous passage of the Lansley Bill, the Government had to concede that the Secretary of State remained politically responsible to Parliament for the NHS, which, as we have just discussed, has always been the reality.

It would be brave, however, for someone to suggest that the mandate has had the same level of parliamentary scrutiny. The mandate is presented to Parliament each year, but is that anything other than a ritual? I do not think *Hansard* records energetic and fierce debates about the mandate, although I am happy to be corrected by the Minister, if he can point me to a particular section.

The idea of the mandate is not entirely without merit. It is good that the NHS knows what is expected of it, and we all agree that it should be free from sudden announcements or other surprises—such as the Secretary of State announcing that the following week all NHS staff would have to wear face coverings before informing them that that was what was required. That is just one example from an extreme situation, but the point is that we all crave certainty. The mandate is an attempt to provide that; and without it, it is unclear how accountability works.

As was clearly articulated in last Thursday's evidence session, the NHS welcomes the mandate's ability, in theory at least, to give it stability and enable it, if possible, to plan for the medium and long term. I am sure we could have a debate on whether that is indeed what has happened; it is pretty clear in recent times that, for genuine reasons, that has not been possible. However, most experts would suggest that the NHS would benefit from stability and the ability to plan over at least a three or five-year period without lurches in policy and—crucially and pertinently given today's business in the Chamber—with a degree of funding certainty to match the requirements.

10.15 am

Despite the NHS long-term plan, which the Minister and I worked on in what seems like another era, the NHS still has to go to the Treasury with a begging bowl every year to try to get the funding it needs. That is as relevant in any area as it is in the workforce. No doubt we will return to that later, but with an NHS so dependent on staff who rightly have many years of training before they can take on their roles, long-term planning is the optimum process, not the annual round of deckchair moving that we often see.

Before the mandate concept entered our terminology, the NHS had to use other means to work out what was expected of it. Under both approaches, NHS England had to set out various flavours of operating plan to keep the NHS going and to try to deliver on the political aspirations and directions of the Secretary of State and the Government of the day. It would be valuable to reflect on that and what those who run the NHS think of the mandate and how effective it is—or to put it another way, how it can be made an effective part of governance and accountability, particularly in this place. The idea of the mandate being for a longer period, being amended only when something serious happens—perhaps on the scale of a financial crash or pandemic, as the most recent examples—has merit.

The Minister may well concede that long-term planning and political stability is of benefit to the NHS, but will he reflect on two matters raised in the amendments? First, a change to a mandate during its natural term could be hugely disruptive, so there should be some requirement, as set out in our amendment, for the Secretary of State to do that only in urgent circumstances, and to show Parliament that the need to change the mandate outweighed the destruction and costs of doing so. The last 18 months demonstrate what urgent circumstances look like, but we would not want to try to list them, because no one can predict the future.

Secondly, any mandate without a proper financial analysis will always be open to question. The setting of the mandate must be tightly linked to the allocation of funding, not entirely divorced from it, as it appears to be. That requires a better relationship between the Secretary of State and the Chancellor, but as we now have a former Chancellor as the Secretary of State, he may harmonise decisions more effectively, or he may know the tricks and minds of those in the Treasury and can navigate them more proficiently. We will see, but that is certainly not something we can put into the Bill.

Widely published evidence provided to us suggests that in the year before the pandemic, the NHS had an effective deficit of £5 billion. That is the gap between the cost of delivering what the Ministers put in the mandate and what they are actually paying for. That is against what we consider an entirely unambitious scenario, where the NHS was not reducing waiting times—they were increasing—and a whole suite of performance indicators were going backwards. The Commonwealth Fund has shown the impact of that inadequate funding, as it slides down the league table. Just about everyone agrees that that was an inevitable consequence of the decade of austerity that we endured.

Time and again, we have heard various parts of the NHS being asked to do things that have not been funded adequately. Providing inadequate funding is an old trick of blame shifting, with blame deflected when delivery does not happen. The Minister is a former member of a local authority, as I am, and he will be familiar with that tactic—possibly under more than one Government. The suspicion of blame shifting is something to which we will return when we look at ICBs. We do not want them to suffer the same fate as local authorities, which have to pick up the pieces when inadequate decisions are made in Whitehall.

All of this points to the need to restore credibility in a system that asks for things but does not pay for them. Assessments to accompany proposals are a well-established

measure. Bills have to have various assessments—after all, we have to assume that plans in the mandate have been costed—so it should be the case that most of the work required by the amendment is already being done. Why not secure an assurance that costings will be published, as that will give us the confidence that transparency would provide?

The Minister will know that I have had to regularly chastise him in delegated legislation Committees, because statutory instruments, particularly on covid measures, are virtually never introduced with an impact assessment. I was prepared to allow some latitude at the beginning of the pandemic, as the need for swift action was understandable, but the regular rhythm of the Department appears to show that impact assessment are not something that is important. We believe that they are, and when talking about the Government's political direction for the NHS, the need for them is evident. I am pleased that an impact assessment has now been provided for the Bill, although I understand that it was published only yesterday. Again, that is characteristic of the feeling that impact assessments are an option, not a necessity.

Amendment 19 would require urgent changes to be accompanied by a written statement explaining the reasons for the urgent provision mandate, which should be accompanied by an impact assessment. I hope the Minister accepts that by asking for that I am trying to help him out again, and trying to get him out of the bad habits into which he has fallen recently. It could be said that what is taking place in the Chamber today is the reverse of what we are proposing—it is a revenue-raising exercise without any clear idea about what will be achieved. We do not even know how much of that will be allocated to the NHS and how much to social care. How can any system properly plan if funding is allocated on that basis? We are told that there will be a further White Paper on integration. *[Interruption.]* Perhaps the Minister will respond to that point when he replies to the debate, and tell us what is missing in the Bill that requires further legislation on integration.

Finally, I refer the Committee to the evidence from the King's Fund in particular. Richard Murray told us last Thursday:

> "The idea that each year, some time between December and March, you can set a different expectation on the NHS, is operationally unreal for the system. They cannot do it, so I think we want to get back to something where you set out a clearer medium-term objective for the things you want the NHS to achieve, whether that is reduced waiting times or better health, and allow them to try and work towards it. Budgets on that basis would also be incredibly helpful—if you are working in the service not knowing what capital you might have two years down the line and what revenue you might have."

He also said:

> "I would strongly encourage the Government to also try and set multi-year settlements for the NHS, as used to be done, so that people can plan at local level."

Nick Timmins of the King's Fund said:

> "If memory serves me right, the original idea of the mandate was a rolling three-year mandate. You set the objectives of the NHS and what you want it to achieve, and you can have a little review of it each year, but it is clear. I probably should have said that if the money was also planned on the same basis, that would help no end."—[*Official Report, Health and Care Public Bill Committee,* 9 September 2021; c. 127, Q174.]

I hope that the Minister accepts that we are trying to be helpful in the amendment, and I await with interest his reply to the points that I have made.

Dr Philippa Whitford (Central Ayrshire) (SNP): I wish to make one simple point, following what the right hon. Member for Ellesmere Port and Neston has said, which is that the annual funding of any health system based on the tax year—I can speak to this, having spent more than three decades on the frontline—means that clinicians will inevitably be contacted in January or February and asked, "What equipment do you need? You have to obtain it by 31 March." Providers of medical equipment will happily admit that prices go up in the first quarter of the year and then drop, so this hand-to-mouth method actually costs all health services massive amounts of money. Simply being able to smooth that out so that we know what is coming several years ahead would save millions of pounds on procurement and allow that money to be directed to clinical care.

Karin Smyth: I echo the comments of my hon. Friend the Member for Ellesmere Port and Neston. The mandate is important. It is awaited by clinicians and managers in the health service as it affects how they are to operate in the forthcoming year. Often guidance arrives the week before Christmas, as I remember from my time in the NHS, so we were starting to plan for the very short term, which really is unhelpful. It is a regular statement intent, and it is a way in which the public can see what is happening or is due to happen to their services.

My hon. Friend the Member for Ellesmere Port and Neston quoted from the King's Fund's written evidence, which mentioned the

> "multiple plans and strategies in each ICS"

and the need for a "more 'local' place level". As we heard in our evidence sessions, this is already a very confused picture, and one that we are going to try to navigate our way through. Although I do think that there should be greater permissiveness, so long as it is accountable at local level, the mandate gives us a degree of accountability at national level, on the Government's intent, published in their stated aims, and that gives the general public and taxpayer confidence.

On our amendment about 18 weeks, that target was often criticised as not being clinically referenced. It was brought in after the then Conservative Government talked about an 18-month target being highly ambitious for people waiting to be seen clinically—some of us are old enough to remember those dreadful days, to which we have returned. Now, we could argue whether 18 weeks was the right number, but it was something that drove up standards of care, and it meant that the NHS said to the taxpayer, "We accept that you deserve a better standard of care and treatment, and it is completely unacceptable to be on a waiting list for 18 months to two years"—it was often longer. It focused minds, drove service redesign and made clinicians go back over their lists, because if someone has come on to a list two and a half years earlier, many things would have happened and, sadly, in many instances that person would have died.

By supporting our amendment, the Government would show that they are ambitious for the NHS and the people it serves. If the Minister is not prepared to support that 18-week commitment, what is acceptable to the Government? We and all our constituents know that waiting lists were rising out of control before the pandemic, and that the target had not been met for several years. Clearly the pandemic has exacerbated the situation, but let us be clear that targets not being met was a pre-pandemic problem.

We hear utterances from the Government in the newspapers about what they think about the targets—"nonsensical" is what the Secretary of State said at the weekend. The targets were put in place to give people confidence that their taxes were funding a service that they could hold to account in some degree, and it drove some positive behaviour. It will take a massive effort to get waiting lists down, so what discussions has the Minister had with clinicians and managers about the loss of targets? Why would he not support putting that target back in the Bill? The long waiting lists are miserable for everyone concerned. They need to be published. We need to let people know what they can expect from our service. I strongly urge the Minister to accept the amendment, or at least its intent. If he is not prepared to do so, what does he think is an acceptable length of time for people to be on a waiting list?

Edward Argar: The hon. Member for Ellesmere Port and Neston is having a good day; I promoted him to shadow Secretary of State and I think the hon. Member for Central Ayrshire made him a member of the Privy Council, so he is doing well this morning. Although we may resist many of his amendments, I take the point that he did not table them from a partisan perspective but genuinely approached them with sincerity. He mentioned that on a previous occasion the Bill Committee had to be run twice. Fond of him as I am, I think both of us would prefer not to have to do this twice together.

10.30 am

The hon. Gentleman mentioned the impact assessment, which I will touch on briefly. When he goes through it, he will see that it is a chunky document. I reassure him that I have read it in detail, and we published it yesterday in time for line-by-line consideration of the Bill. The reason for the slight delay was that we were keen that it went through the Regulatory Policy Committee properly and received a green rating. The RPC proposed some minor amendments to the original draft, which we thought it appropriate to heed. We updated the impact assessment to make it as comprehensive as possible, which caused a slight delay. However, we were very clear that it had to be published before line-by-line consideration, because I share his view that impact assessments are important documents for Members to have at their disposal.

Turning to the substance of the shadow Minister's amendments, and then to the clause, the statutory mandate for NHS England drives delivery of the Government's top priorities for health and care. The intention of clause 3 as drafted is to increase its effectiveness as a long-term strategic tool, framed in a way that can endure rather than having an annual use-by date. That will further support the NHS in ensuring that it can plan effectively to deliver the Government's longer-term strategic priorities and, in the longer term, meet the health needs of this country, ensuring that public funds are used sustainably to improve services and outcomes over time.

The priorities naturally evolve, based on the Government's collaborative discussions with the NHS and wider Government, as well as insights on where the NHS should focus its resources from patients, the public and their representative groups, and of course staff. Amendment 19 would, however, potentially prevent such flexibility and democratic adjustment, save in response to urgent or unforeseen circumstances. The shadow Minister rightly alluded to what happened during the pandemic as showing that flexibility; however, there may be other circumstances—for example, a change of Government. I do not anticipate one in the near future, but were that at some point to happen he might wish to have the flexibility to change the mandate.

The amendment would require the Secretary of State to justify to Parliament the urgent or unforeseen circumstances that have led to a revision of the mandate, and to provide an impact assessment. I wholly endorse the need for Ministers to ensure that Parliament is kept informed about the mandate. By convention, the laying of every new mandate is announced in both Houses of Parliament by way of a written ministerial statement. That statement explains the approach that has been taken and makes reference to any relevant funding decisions made through the spending review or the Budget.

Amendment 20 would require the Secretary of State to make a written statement to Parliament when laying a revised mandate to explain how the mandate would be funded. Clause 3 as drafted removes the requirement for the Secretary of State to include and give statutory effect to NHS England's annual capital and revenue resource limit in the mandate document. I understand the shadow Minister's perspective, and his concern that there should continue to be appropriate transparency to Parliament for the funding that is made available to the NHS and that, in particular, the delivery of any long-term priorities set in the mandate should be fully funded.

I reassure the Committee that there would be no benefit to the Government, or to any Government, in setting an unaffordable mandate that the NHS is simply not resourced to deliver. Aligning expectations set in the mandate with the funding that the Government have provided, and expect to provide in future, will continue to be a vital part of our consultation with NHS England on the content of each new mandate. NHS England's capital and revenue resource allocations will continue to be set annually and given statutory effect by annual financial directions, as is the normal approach.

Clause 21 provides for those financial directions to be laid in Parliament in the future, adding to the transparency. We believe that the additional requirement for an impact assessment on mandate revisions is therefore unnecessary, as Parliament will see those directions. In future, the financial directions to NHS England will be mandatory, rather than discretionary, and they will give full statutory effect to the limits for annual accounts purposes. I suspect that we will return to that when we debate clause 21. The new duty for the Secretary of State to lay them in Parliament will ensure that Parliament is given a regular assurance on the funding that is being provided to support the delivery of the mandate objectives in the financial year ahead.

Let me address one final point on the amendments, and then I will turn to clause stand part. The shadow Minister and the hon. Member for Bristol South alluded to long-term strategic approaches and asked whether that risked setting a short-term approach, to the detriment of long-term planning. They asked whether Ministers would potentially risk using the new flexibility to replace mandates so frequently that the NHS was unable to do that long-term planning. There will continue to be a

duty to consult NHS England before setting a new mandate, and this process already ensures that the mandate is informed by NHS England's views on the reasonableness of any new expectations set, including in relation to the time that the NHS will need to respond effectively to any new or changing priorities. It is clearly not in anyone's interest that any expectations set could not reasonably be met. Should the Government choose to replace a mandate within 12 months of first publishing it, NHS England would not be legally required to update its day-to-day business plan to reflect that, although it would obviously seek to work collaboratively with the Government.

Clause 3 amends the Secretary of State's powers and duties in respect of setting the mandate. The Secretary of State will continue to be required to publish the mandate and lay it before Parliament. A mandate must continuously be in place so that NHS England's delivery plans are consistently steered by the Government's priorities for health and care, but this clause means that there will no longer be a requirement to lay and publish a new mandate each and every financial year, thereby aiding longer-term thought and planning. Under the clause, such a mandate would remain in force until such time as it is replaced. This change means that it would not have to be revised so frequently. As it would no longer be revised before the start of every financial year, it would no longer be the appropriate vehicle through which to set out the NHS's capital and revenue resource limits or annual ring fences in relation to service integration through the better care fund. Clauses 9 and 21, which we will discuss later, make provision for those amounts to be set instead through annual directions. NHS England's existing legal duties in respect of the mandate remain unchanged, and the Secretary of State will continue to be required to consult NHS England.

The mandate remains the Government's primary mechanism for setting the overall strategic direction of the NHS. As we emerge from the pandemic, this clause is crucial to further strengthen the role of the mandate in driving forward the priorities of the Government and the nation for health and care with a longer-term perspective. It streamlines our ability to adjust course over a shorter period of time where necessary.

Let me make a couple of final points before I conclude. The hon. Member for Nottingham North, from a sedentary position, alluded to multiple consultations, reorganisations and suchlike. He knows the respect that I have for him, but I gently say to him that we should look at what previous Governments did when in power. Under the previous Labour Government, there were reorganisations of the NHS in 1999, 2001, 2003 and 2006. This is only the second major piece of NHS legislation under this Government. On social care, to which he may have been alluding, the Labour Government managed to have two Green Papers, a spending review in 2007 in which it was a priority, and a royal commission, and they still did not manage to get it sorted.

The hon. Member for Bristol South touched on waiting lists. We believe that the clinical review of standards process, which is being undertaken by clinicians, is the right approach for looking at that, particularly in the context of the very unique circumstances in which we find ourselves post pandemic, as we seek to recover waiting times to an acceptable level and reduce waiting lists.

I will pause there. I encourage the hon. Member for Ellesmere Port and Neston to withdraw his amendment, and urge colleagues to support clause 3 stand part.

Justin Madders: I thank the hon. Member for Central Ayrshire for promoting me to the Privy Council. At this rate I will be Prime Minister by lunchtime and supreme leader of the universe by the end of today's sitting, in which case the Bill will no longer be required.

The hon. Lady made an important point about the effect of annual budgets and, frankly, the opportunism that follows from those providing services. We know that happens in all sorts of sectors, but the amendment sets out very clearly why a longer-term footing is needed. What the hon. Lady referred to was a boom-and-bust approach, but we will leave such terms to history.

My hon. Friend the Member for Bristol South articulated clearly some of the challenges as well. She made the point about accountability, which really does matter. As she said, there is a theme throughout the Bill that accountability is somewhat missing. I am grateful for the Minister's explanation of the impact assessment—better late than never. The White Paper was issued in January and the Bill had its Second Reading in July, so there has been plenty of time to get everything sorted.

The amendments seek to stop the Government's propensity to announce policy by headline and then work out the detail later on. The Minister has helpfully said—he will correct me if I am wrong—that the mandate will be fully funded, and we will make sure that he commits to that. We probably do not need to press amendment 20, but we will press amendment 19 to a vote. We think the Government intend to move towards a longer-term plan for the mandate on an annual cycle, but the legislation as it currently stands does not prevent it from becoming stop-start, and there will be circumstances when it will be necessary to change within year. It is important, for reasons of accountability, that that comes with some conditions attached.

The Minister said that we are trying to take away flexibility from the Secretary of State, but we are not. We are trying to encourage accountability alongside flexibility. We accept that there will be circumstances in which the mandate will need to be changed in urgent situations and we would not want to impinge on that, but if the Secretary of State has the power to move things forward in that manner, he should be accountable to Parliament when he does. Again, we are trying to be helpful and assist him. We hope he does not have to do it very often, but if he does issue a mandate in urgent circumstances he will want to know what the impact will be on the NHS. He will want to know that the funding is there and that the NHS has the capacity to deliver the demands placed on it. Those are questions that any member of the Department will ask, so we hope to put in the Bill what ought to happen in practice. It is important enough to press the matter to a Division.

Question put, That the amendment be made.

The Committee divided: Ayes 6, Noes 9.

Division No. 1]

AYES

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

NOES

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

Question accordingly negatived.

Clause 3 ordered to stand part of the Bill.

Clause 4

NHS England: wider effect of decisions

10.45 am

Alex Norris (Nottingham North) (Lab/Co-op): I beg to move amendment 21, in clause 4, page 3, line 5, at end insert—

"(d) health inequalities."

This amendment would modify the triple aim to explicitly require NHS England to take account of health inequalities when making decisions.

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

Amendment 22, in clause 4, page 3, line 5, at end insert—

"(1A) In making a decision about the exercise of its functions, the health and well-being of the people of England must be NHS England's primary consideration."

This amendment would assert that duties to patients come above any other (e.g. organisational) considerations.

Amendment 23, in clause 19, page 18, line 13, at end insert—

"(d) health inequalities."

This amendment would modify the triple aim explicitly to require integrated care boards to take account of health inequalities when making decisions.

Amendment 24, in clause 19, page 18, line 13, at end insert—

"(1A) In making a decision about the exercise of its functions, the health and well-being of the people it serves must be the primary consideration of an integrated care board."

This amendment would assert that duties to patients come above any other (e.g. organisational) considerations.

Amendment 25, in clause 43, page 47, line 32, at end insert—

"(d) health inequalities."

This amendment would modify the triple aim to explicitly require NHS trusts to take account of health inequalities when making decisions.

Amendment 26, in clause 43, page 47, line 32, at end insert—

"(1A) In making a decision about the exercise of its functions, the health and well-being of the people it serves must be the primary consideration of an NHS trust."

This amendment would assert that duties to patients come above any other (e.g. organisational) considerations.

New clause 13—*Secretary of State's duty to set targets on population health and reduction of inequalities*—

"(1) The Secretary of State must, at least every five years, publish a report setting targets on—

(a) the improvement of the physical and mental health of the population, and

(b) the reduction of health inequalities.

(2) The Secretary of State must publish an annual report recording progress against the targets in subsection (1)."

Alex Norris: It is a pleasure to serve with you in the Chair, Mrs Murray, and to make my first contribution to the proceedings. It will perhaps give my hon. Friend the Member for Ellesmere Port and Neston a chance to bask in his new-found responsibilities, while I pick up the cudgel with the Minister. I am afraid I do not have such luxury as he does.

This group of amendments relates to health inequalities and to the priority that we give to the health of the nation, rather than the structures that serve the health of the nation. I will go through each amendment in turn, but I want to talk about a couple of themes that cover them all.

I strongly believe that addressing health inequalities ought to be a foundational priority of any Government of the day. What could be crueller than having such a significant element of a person's future—how long they will live, how long they will live in good health and what diseases they are likely to acquire—preordained at birth? That has always seemed cruel to me.

Government are not a passive part of that process. The decisions that are taken in this place play an active part in those inequalities. For example, the decisions taken later today and on universal credit will widen them. We should seek to use this Bill as a turning point in our battle against health inequalities in this country. This should be the Bill in which we say that the national health service, and those who need it locally, must be central to addressing health inequalities in this country and that the Government will resource them properly to do so.

It is not a moment too soon to do this. The legacy of this decade of austerity, which my hon. Friend the Member for Ellesmere Port and Neston talked about, is that for the first time in a century the increase in life expectancy has stalled. What does it say about us, the most technologically advanced generation in history, that the increase in life expectancy stalls on our watch?

Within that there is a yawning gap in healthy life expectancy between those who live in the best-off and the worst-off communities. On the basic life expectancy measure the gap is 10 years, but on healthy life expectancy, measured by the age at which people have their first disability, the gap is 18 years between communities like mine and the communities that are best off in this country. How sad that is; how sad is what it says about us.

As the 2020 Marmot review concluded,

"health is getting worse for people living in more deprived districts and regions, health inequalities are increasing and, for the population as a whole, health is declining…the country has been moving in the wrong direction."

Again, we heard evidence about that in the evidence sessions of this Committee. We ought to use this Bill as a moment to do something about it.

These inequalities are not just about socioeconomic status; they are about race as well. Research by the King's Fund shows that

"people from the Gypsy or Irish Traveller, Bangladeshi and Pakistani communities have the poorest health outcomes across a range of indicators."

Covid has shone a light on both race and socioeconomic background as drivers of inequalities. We entered the pandemic thinking it would be a great leveller and that the virus would not know people's postcode, job or ethnicity. Actually, we quickly learned that that was not

[Alex Norris]

the case and that someone was twice as likely to die from covid if they lived in the most deprived communities. A man from a black African background is nearly four times as likely to die of covid as I am. Those inequalities, and how they played out, whether in housing, in occupation or pre-existing health, offered a breeding ground for the virus. That is devastating for individuals, but it is worse for all of us, because it has spread and strengthened the virus. Those health inequalities are bad for everybody.

Just before I turn to my amendments, I should also say that it is strange, given that half of all health inequalities are driven by smoking, to see a Health and Care Bill that does not talk about smoking at all. I hope that when we get to part 5, where some of the public health elements are found, we might collectively do better there.

Amendment 21 seeks to address the point about inequalities by adding to the triple aim for NHS England as set out in clause 4. The triple aim for the national health service is a good thing. It shows the system and those who work in it and lead it, whatever their role, what we want them to prioritise. The three strands of that triple aim are noble: the health and wellbeing of the people of England, the quality of service provided and the efficiency and sustainability of resources. However, that is not robust enough to ensure not just due regard for health inequalities but strong action.

I will not prejudge what the Minister will say, but I suspect he may say that promoting the health and wellbeing of people in England is the aim that covers inequalities. That is an important pursuit, but it is not explicit enough. It is just about general improvement. For example, we hope the Government would expect to see a resumption in the increase in life expectancy. That would be a general improvement in the health and wellbeing of the people of England. The problem with that is that it would not address the point about healthy life expectancy. There would be general and maybe even aggregate improvements for possibly a great deal of the population, but not enough to deal with the extraordinary and growing gaps for others. I think we ought to want to do something about that.

Accepting the amendment would mean the Government would send a signal to NHS England that tackling health inequalities ought to be at the centre of its mission. A quadruple aim may not be as elegant as a triple aim, but it is important that tackling health inequalities is recognised in the Bill. I know that the Minister wants the legislation to stand the test of time. He suggested I said something from a sedentary position about multiple pieces of legislation, which I genuinely believe I did not, but we ought to say that we are here because the 2012 Act was so bad. That there have been nine years since that Act is not a strength on the Government's part; it is a weakness that they have defended something that has not worked for a long period of time. If we want the Bill to stand the test of time, then we ought to say what we want the health service to do. By putting that in the Bill, we would do that.

Amendment 22 also addresses the triple aim and creates a hierarchy within. High-quality and sustainable services are important, but when commissioning decisions are being made at a national level, as happens with NHS England, and those decisions affect our constituents, we do not want equal weight being given to organisational considerations. The whole point of the Bill as explained on Second Reading is to move to an integrated system that is built around the health and care needs of the population, rather than around organisational boundaries. We all recognise where that butts up in our casework and the frustration that that causes for us and, more importantly, for our constituents—those who have to make multiple calls to arrange care for loved ones and so on. If that is our purpose here, we want health and wellbeing to come first. The amendment seeks to do that and says that the primary aim of the three is the health and wellbeing of the population. If that means that there is a knock-on effect on political decisions on funding, as discussed in the previous set of amendments, so be it. It will be for the Government of the day to ensure that NHS England has the resources to do that well.

I draw the Minister's attention to the very recent precedent in the Medicines and Medical Devices Act 2021, the Bill Committee for which took place in this room or an identical one. I was a member of that Committee, as were the hon. Member for Bury St Edmunds, who is not in her place at the moment, and the hon. Member for Erewash. When we discussed the triple aim of that Bill, I moved an amendment to prioritise patient safety over all other considerations, because I thought that was an uppermost consideration. It was originally rejected in Committee, but the Government brought it back in later stages, which was the right thing to do. Rather than waiting to bring this back later, we could address it today. I would be very interested to hear the Minister's comments on that.

Amendment 23 is a counterpart to amendment 21, but it operates at local level. Whereas amendment 21 applied to NHS England, amendment 23 applies to local integrated care boards—to say that, as part of their responsibilities, they must take inequalities into account. Of course, all the arguments that I have made for NHS England also apply here, so I will not repeat them, but this is quite a profound case at local level. From the written evidence, the hearings and the contributions from hon. Members throughout the Bill's stages and elsewhere in this place, we can see that there is considerable anxiety that we will end up devolving fixed financial settlements down to the integrated care system level. That suits Ministers, because it means that they can devolve financial responsibility so that the Treasury can know what it is spending on a certain function, but all the tough decisions that get us to that point have to be taken at local level. I do not think that is a dystopian scenario, because that is literally what we do with social care already in local government.

The Government know that they do not resource local authorities sufficiently. As a result, social care is squeezed. What happens in those circumstances is that the systems start to worry about running out of money. The hon. Member for Central Ayrshire made a point about end-of-year capital that I recognise from my time in local government, but it works in reverse—when Christmas comes about, there is a spending freeze on everything, and the chief executive of every council in the country ends up reviewing every purchase of more than about a fiver. That is the reality for the systems, and local commissioners will be pressured to think in

the interest of resourcing their system, rather than tackling health inequalities. That runs straight into the argument for amendment 24, which is a counterpart to amendment 22 and which says that the hierarchy within the triple aim ought to apply at an integrated care system footprint.

In paragraph 44 on page 18 of the explanatory notes, the Government have told us that the purpose of the triple aim duty is to

"require organisations to think about the interests of the wider system".

I get that, but I do not think it is quite right, because the primary responsibility is to think about the interests of the wider population. It flows from there that the best way to address the health needs of the population is a system-based approach, which is the Minister's central argument for this entire piece of legislation—so organisations have to think about each other. However, the primacy is the need of the population.

Perhaps the Minister will say it is axiomatic that health systems will prioritise the wellbeing of their community above everything else, but I do not think it is inconceivable at all that at some point in any given year—never mind at some point in the future—system leaders in one of those footprints will feel distressed about their finances and may take the wrong message, or perhaps the wrong bit of cover on a commissioning decision, about putting population wellbeing in the same tier as system sustainability, as if those two things could be co-equals and, if in tension, could be resolved either way. I do not think that is right, and I would be interested to hear the Minister's view on that.

Amendment 25 requires health trusts to pay regard to "health inequalities". Again, it is a counterpart to amendments 23 and 21, and it is for the same reasons as for NHS England and integrated care boards, so I will not repeat those arguments.

Amendment 26 is a counterpart to amendments 24 and 22, requiring the prioritisation of population health and wellbeing at trust level, for the same reasons that I have just mentioned. Again, I will not repeat those arguments.

11 am

I turn lastly to new clause 13. As I said at the start, the Bill should be a turning point for health inequalities, rather than being known as the legislation that knocked the 2012 Act into the bin or as essentially a commissioning restructure and organisation. It ought to be the legislation where we got serious about health inequalities in this country. To do that, we need to understand them better. To do that, the Government of the day need to be more accountable for them. To do that, crucially, we need to be more honest about what they are. Otherwise, we get stuck in the ping pong of statistics, which does not serve anybody.

The proposed new clause has that effect. It asks Ministers to look at and state the health of the nation, and to set targets to improve it. It is a modest ask; it asks the Government to do that only every five years. That again reflects the driving principle behind it and the action I would like to see as a result. It is not a short-term attempt to get some good headlines or avoid criticism. It is about meaningful, long-term change, very much in the spirit of the previous set of amendments. Think about what could be done: an attack on smoking and obesity; action to tackle the effect of alcohol and substance abuse. All of those are a problem in this country and we know we can do something about them.

The written evidence from Barnardo's concluded that children growing up in England face some of the worst health outcomes in Europe, particularly those growing up in poverty. That should sadden us. It behoves us to be honest about it, set targets and attack it. The proposed new clause would set the right framework to compel Ministers to do that. Tackling inequalities ought to be at the heart of any Government. The proposed new clause and amendments would improve this Government's approach and that of future Governments.

Dr Whitford: I rise to support these measures. The longer those of us who work in the NHS spend on the frontline, in particular as a breast cancer surgeon in a specialist area, the more we realise that we are constantly catching someone who falls, instead of building a handrail to stop them falling in the first place. Anyone who works in health or social care recognises that health inequalities are a major issue, going right back to the Marmot report of 2010, the Black report and, indeed, many decades. Therefore, they should be a priority at every single level.

The public have a real appetite to see a different approach after covid, because they are aware that covid was not a leveller. It absolutely hit the weakest, most vulnerable and poorest communities. To change the prioritisation to health and wellbeing is also critical. More money is spent picking up the pieces than investing in health in the first place. That is often the health of children; we should try to tackle child poverty and the issues that come from that.

I took part in a report in 2016 that heard from the UK Faculty of Public Health that the UK loses 1,400 children a year before the age of 15, as a direct result of poverty and deprivation. It is clear that the aim of the Bill is not just to take away the appalling section 75. It is to drive integration and the health of the local population. That should be set as a key priority, if the aim is to come out with an approach of putting health in all policies, within local government, the ICS boards and the NHS.

Karin Smyth: I concur with the comments of the hon. Member for Central Ayrshire and my hon. Friend the Member for Nottingham North. The hon. Lady referenced the Black report, which first got me interested in working in the health service. I was shocked that, after all those years, the NHS had not improved the dreadful health inequalities that much of the population, including my own constituents, suffered. Here we are 40 years later, and we still have some really quite shocking health inequalities, even in the wealthy city of Bristol.

This is a really important point. We learned a lot in the pandemic, and hon. Members spoke about meeting their directors of public health recently. I have known my director of public health in Bristol for some 20 years because we have worked together over that period. I supported the movement of DPHs into local authorities. I think that was the right move, although the lack of funding that followed has made their job really difficult, and we have not made the improvements we should have made, as my hon. Friend the Member for Nottingham North outlined.

[Karin Smyth]

There is real enthusiasm among clinical and financial leaders for some of the movement in the Bill to bring organisations together in integrated care partnerships or ICSs—wherever we think the power will be—to look at population health. Financial directors I have talked to have said, "This is the direction we need to be going in. We need not to be looking just at our own institutions." There is a will with the Government, but not including health inequalities is a major mistake. I appreciate that when they drafted this legislation, they were perhaps not thinking in that form, but a number of organisations have asked for that addition to be made.

The pandemic required us to talk closely to our clinical leaders, and it really educated people in individual specialties, who are not terribly knowledgeable about health inequalities—perhaps we think they should be. Even in terms of our understanding of where vaccines have been successful and unsuccessful, and how different communities receive information and engage with local health and care services, the pandemic has been a wake-up call and a good education for many of those leaders. We need to capitalise on that.

I know that drafters do not like to change things, but if we were to put addressing health inequalities in the Bill, as we seek to do, it would focus the Government's drive on place-based commissioning and service delivery, and send a message to the powerful acute trusts—which at the end of the day run the money, and still will—that addressing health inequalities and looking at where and how their services are delivered to the most vulnerable will be a really positive outcome for the entire system. I therefore support the pursuance of the amendments.

Hywel Williams (Arfon) (PC): To encourage the Minister to accept the amendment, I point out that addressing health inequalities would coincide with the Government's stated aim of levelling up, so there is a happy coincidence there that might persuade him. Health inequalities are reflected geographically, and large parts of the country clearly suffer from them more than others. That pertains to England, but were I standing in the Senedd in Cardiff, I would say the same about Wales. That is slightly off the point, but there we are.

Edward Argar: I am grateful to the shadow Minister and all other hon. Members who have spoken for the expertise that they bring to this debate. It is one of the quirks of this House that lawyers are hon. and learned Members and members of the armed forces are hon. and gallant Members, but we do not have an equivalent for those who serve in the medical profession. Perhaps we should think about that.

I am very grateful to hon. Members for bringing this debate to the Committee by tabling these amendments, which relate to the important issue of health inequalities, in the context of the new triple aim duty set out in the Bill. Even though we may not reach the same conclusions about the best way to do it, it is right that we debate this crucial issue in Committee.

With your consent, Mrs Murray, and that of the Committee, I will start in reverse order with new clause 13, and then work my way through the amendments of the hon. Member for Nottingham North. The new clause would place an additional duty on the Secretary of State to produce a report setting targets on the improvement of the physical and mental health of the population and the reduction of health inequalities.

I appreciate and understand the intention behind the hon. Gentleman's new clause. He is right: health is the nation's greatest asset. Preventing ill health, improving people's health and wellbeing, and tackling long-standing inequalities are all fundamental to the economic and social strength of our country. However, the creation of a new statutory duty to set the type of target identified in the new clause is not necessary, in the light of the existing duties on the Secretary of State around improving public health and seeking to reduce health inequalities, as provided for in the 2006 Act. I may not agree with everything in it, but I pay tribute, where it is due, to the Labour party. Labour Members will hear a number of references to what is in that Act and to the retention of what is in that Act in many areas.

Of course, ICBs, too, have duties to have regard to the need to reduce health inequalities whenever they are exercising their functions, to promote integration where it would reduce health inequalities and to set out how they will tackle health inequalities in their plans.

I hope I can reassure members of the Committee that the Government are already taking strong action in these areas and that there are already a number of targets relating to improving the population's health that cannot be met without addressing those underlying inequalities. For example—I know that this is something that the hon. Member for Nottingham North feels very strongly about—we cannot achieve our existing commitment to a smoke-free generation by 2030 if we do not address as a priority the needs of those people and populations with the greatest levels of need and help people to give up smoking. He is right, and this involves the Under-Secretary of State for Health and Social Care, my hon. Friend the Member for Bury St Edmunds. I suspect that when we reach the latter parts of this legislation that are about public health more specifically, this issue may feature, rightly, in the Committee's discussions again.

To support our strategy to improve the population's health and reduce health inequalities, at the beginning of October we will launch the Office for Health Improvement and Disparities within the Department. We have also announced that we will create a cross-Government ministerial group with a remit specifically to identify and tackle the wider determinants of poor health. Our broader focus on levelling up, to which the hon. Gentleman alluded, recognises the wide range of factors such as good jobs, homes and local environments in which we can take pride, alongside a range of other factors, that all support and interact with our physical and mental health.

In contrast, I fear that the new clause, although I can see its intent, could make it more difficult for us to swiftly focus on ensuring that such inequalities are identified and acted on. Had we a fixed, five yearly set of targets to work towards, I fear that it would introduce more rigidity, rather than the agility and flexibility that we seek in meeting the changing assessments of what underlying health inequalities must be tackled as a priority. I hope that I can persuade members of the Committee, although perhaps not all of them, that a five-year fixed plan is potentially inflexible and is not necessary in the context of this legislation.

I turn now to the amendments that relate to the duty known as the triple aim. Amendments 21, 23 and 25 would add a fourth limb of tackling health inequalities for NHS England, ICBs and NHS trusts. As I have stressed, we do recognise the importance of tackling health inequalities, but again, we do not feel that the amendments, however well intentioned, are necessary. As we have discussed, there are existing statutory duties on bodies in this area, many of which relate specifically to health inequalities. NHS England and ICBs will have to have regard to such duties alongside the limbs of the triple aim. NHS England will also have to consider such duties when it produces the guidance on the triple aim.

The triple aim is compatible with and conducive to addressing health inequalities and furthering the delivery of these duties. Indeed, tackling health inequalities is a theme that runs throughout the duties. Having organisations consider the wider effects of their decisions will, we believe, encourage greater collaboration and engagement with communities on how best to meet their needs, which in turn will assist with tackling health inequalities nationally, but also flexibly at a local level.

The triple aim duty requires consideration of the health and wellbeing of the people of England. As the shadow Minister alluded to, that would also include consideration of the health and wellbeing of those who are not accessing health services. Similarly, it is a key element of the second limb of the triple aim—the improvement of the quality of services—to consider those areas where services are in most need of improvement. We expect guidance from NHS England to make clear how bodies can discharge the triple aim duty in a way that is fully commensurate with the reduction of health inequalities.

11.15 am

Amendments 22, 24 and 26 would require NHS England, ICBs and NHS trusts to prioritise one limb of the triple aim above all others, prioritising the health and wellbeing of people in England above the quality of services provided to individuals in the health service and the sustainable and efficient use of resources. We fear that this would fundamentally undermine the intention of the triple aim duty, which is to require NHS England, integrated care boards, trusts and foundation trusts to think synergistically about the interests of the wider system as the provider of the solution to improve health inequalities when making decisions, balancing the different aspects of the duty. Rigidly prioritising one limb over the others could, we fear, lead to worse or unbalanced decisions being made. The triple aim is designed to be applied in a wide range of situations where that balance would be more appropriate.

To summarise my comments on the amendments, I remind the Committee that NHS England will make it clear in guidance how the various limbs of the triple aim should be balanced in specific situations, including in addressing both health inequalities and the health and wellbeing of the people of England, and in providing appropriate support to these decisions without a fixed or rigid requirement to always place one set of effects above the others. I hope I have persuaded the hon. Member for Nottingham North not to press his amendments to the vote, although I suspect I may be out of luck on this one.

Clause 4 places a new duty on NHS England to have regard to the wider effects of its decisions on the system as a whole. This duty, which was described in the long-term plan as the triple aim, is mirrored for English NHS trusts, foundation trusts and the proposed ICBs. NHS England will be able to produce guidance on this duty, with a requirement to consult those it considers appropriate. All bodies to whom it applies must have regard to that guidance. The duty is also given effect by clauses 19, 43 and 57.

The three limbs are that NHS England 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 relevant NHS organisations, and the sustainable use of NHS resources.

Clinical and commissioning decisions about individuals are explicitly excluded from this duty by subsection (2). This is relevant to NHS England because its functions include making commissioning decisions about highly specialised treatment for some individuals. It would not be practical or appropriate to apply this duty to decisions about the services to be provided to a particular individual.

The existing duties on NHS bodies have encouraged a focus on the interests of each organisation and those who directly use their services. While the delivery of high quality services of course remains critical, this new duty will complement other changes in the Bill to facilitate co-operative working and integration, encouraging NHS organisations to go further in supporting their communities beyond the people they directly provide services to and to consider collaborative system-wide goals. We believe that clause 4 is essential in encouraging the components of our health system to work together co-operatively and considerately, with an awareness of the wider effects of their decisions.

I therefore encourage the shadow Minister not to press his amendments to the vote and commend clause 4 to the Committee.

Alex Norris: Turning briefly to the points made by colleagues, the hon. Member for Central Ayrshire made the same arguments I did about patient safety and the Medicines and Medical Devices Act 2021. She made very good points about the health and wellbeing amendments, and I thought she was right to say that there is a real public appetite, now in particular, to tackle inequality. I do not think the public would be surprised to see the Government enter this space.

The hon. Member for Arfon made a similar point about whether levelling up is a political slogan or a public policy programme. It is very hard at the moment to find evidence for the latter, but this would be a really good piece of evidence for it. It is not just a north and midlands versus south issue. As my hon. Friend the Member for Bristol South said, there are some constituencies, like my own, where every single super output area would be in the hardest pressed decile in the country. However, there are many more where there is a greater range—they have some of the poorest parts of the country, but they also have some of the best off. This is something that ought to be at the top of the priority list for every integrated care system in every constituency.

[Alex Norris]

On new clause 13, the Minister said that five years is too rigid. He almost suggested that the Government might outperform. I will believe it when I see it, but there is no evidence from the last 11 years to suggest that that is in any way a risk. Nevertheless, if he brings this back with a two, three or four-year time period rather than five, I will be the first to join him in the Division Lobby to support it.

On amendments 21, 23 and 25, the idea of a "fourth limb" made it work conceptually—I quite like that. What I did not give much succour to was the idea that inequalities lie somewhere else on the statute book, in a way that health and wellbeing and organisational sustainability do not, and therefore it would not need that co-equivalence because it already exists. I did not agree with that point at all.

On the point about inequalities being part of the guidance, I suspect that that will not be the last time that is said in this Committee. Guidance is guidance; legislation is legislation. One of those is an awful lot more powerful and eminent than the other. My view is that if we want to send a clear signal about something, we do not take it out and stick it in the guidance.

I do not give much succour to the point about elevating one of the triple aims either. The Minister said that that would undermine the triple aims. He talked again about the interest of the wider system, but I think all of us are more interested in the wider population. One of those clearly comes before the other. The needs of the one flow into how to organise the system. To organise a system that is supposed to come together in the interests of population health, I would really like to think that population health is more important than the system. I am not sure about the idea that, as a result, worse decisions would be made, and I would be interested in hearing an example. I have to say that that point did not resonate with me.

I am conscious of the reply from the Minister and, indeed, of the time, so I will not press new clause 13 and amendments 22 to 26. However, I do wish to push amendment 21, because if we are talking about NHS England—that totem of healthcare in our country—I really think we ought to send the signal that health inequality should be one of its priorities.

Question put, That the amendment be made.

The Committee divided: Ayes 6, Noes 9.

Division No. 2]

AYES

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

NOES

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

Question accordingly negatived.

Clause 4 ordered to stand part of the Bill.

Clause 5

Public involvement: carers and representatives

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

Edward Argar: The clause places a new requirement on NHS England to consult and involve carers and representatives of those individuals to whom health services are provided when exercising its commissioning functions. NHS England is currently required to involve and consult individuals to whom healthcare is provided when carrying out its commissioning functions; the clause extends that existing requirement to consulting with their carers and representatives as well. We want to ensure that we have a health and care system that is accountable and responsive to the people who rely on it.

The clause recognises the immensely important role that carers and representatives play in supporting our health and care system, and ensures that our legislation remains in step with current practice within that system. I therefore commend the clause to the Committee and hope that all Members feel able to support it.

Justin Madders: I am sure we are all excited to get this one passed—I am certainly not going to oppose it. However, I have a couple of questions of clarification.

11.25 am

The Chair adjourned the Committee without Question put (Standing Order No. 88).

Adjourned till this day at Two o'clock.