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HEALTH AND CARE BILL

Eleventh Sitting

Thursday 23 September 2021

(Morning)

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Monday 27 September 2021

The Committee consisted of the following Members:

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

† Argar, Edward *(Minister for Health)*
† Bhatti, Saqib *(Meriden)* (Con)
† Crosbie, Virginia *(Ynys Môn)* (Con)
† Davies, Gareth *(Grantham and Stamford)* (Con)
† Davies, Dr James *(Vale of Clwyd)* (Con)
† Double, Steve *(St Austell and Newquay)* (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)
Timpson, Edward *(Eddisbury)* (Con)
Whitford, Dr Philippa *(Central Ayrshire)* (SNP)
Williams, Hywel *(Arfon)* (PC)

Huw Yardley, Sarah Ioannou, *Committee Clerks*

† attended the Committee

Public Bill Committee

Thursday 23 September 2021

(Morning)

[Mrs Sheryll Murray *in the Chair*]

Health and Care Bill

11.30 am

Clause 51

Licensing of NHS foundation trusts

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

The Chair: With this it will be convenient to discuss clauses 52 to 56 stand part.

The Minister for Health (Edward Argar): It is a pleasure to serve under your chairmanship once again, Mrs Murray. With your indulgence, I will speak to each of the clauses in turn.

Clause 51 amends section 88 of the Health and Social Care Act 2012. Section 88 requires that Monitor—or, in future, NHS England—treats an NHS trust that has become an NHS foundation trust as having made an application and met the criteria for a licence. The clause will require NHS England to apply that provision when that queue of NHS trusts waiting to become foundation trusts do so—*[Laughter.]* I hope the Committee will forgive my gentle reference to what the shadow Minister said last time. On a more serious note, the clause will also require NHS England to apply it when a foundation trust is created as a result of the merger of an existing foundation trust with an NHS trust or another foundation trust, or the separation of one foundation trust into two or more new foundation trusts.

Clause 51 clarifies the situation when new foundation trusts are created, merged or separated and ensures there is no unnecessary bureaucracy as a result. It is an important clarification for NHS England on how to exercise its licensing powers in such situations, should they arise.

We are investing record levels of capital expenditure into the NHS to help it build back better after the pandemic. We intend to set capital expenditure budgets at integrated care board level, and we expect providers to work with ICB partners to agree capital expenditure, in line with the ICB capital plan. To ensure that the interests of the wider system are taken into account at individual provider level, clause 52 provides a new power to allow NHS England to make an order imposing capital expenditure limits for NHS foundation trusts.

That narrow and reserved power will ensure that a limit can be set only for an individually named foundation trust for a specified period, and would automatically cease at the end of that period. The power relates solely to capital expenditure and not to revenue expenditure. NHS England must also consult the foundation trust before making the order. There will be clear transparency, as the order will be published.

In applying to an individual foundation trust in particular circumstances, the power stands in contrast to the capital limits that apply to all NHS trusts. The power is likely to be used where there is a clear risk of an ICB breaching its system capital envelope as a result of non-co-operation by that foundation trust, and when other ways of resolution have been unsuccessful.

NHS England must set out in guidance the circumstances in which it is likely to set a capital limit and how it will calculate it. NHS England intends to work closely with foundation trusts to develop that guidance. I want to make it clear to the Committee that the clauses are not intended in any way as an erosion of the autonomy enjoyed by foundation trusts. Unlike NHS trusts, foundation trusts will continue to have additional financial freedoms, such as the ability to borrow money from commercial lenders. However, the clause is crucial for managing NHS capital expenditure across a system and to ensure that all NHS providers operate within the ICB capital limits. Without that control, other NHS providers may have to reduce their capital spending to ensure that the NHS lives within its allotted capital resources and that resources are spent in a way that best delivers for patients and the taxpayer.

The provisions in clause 53 are largely a consequence of the merger of NHS England and Monitor, in this case reflecting Monitor's oversight role in relation to foundation trusts. Subsection (1) gives foundation trusts greater flexibility in their forward plans. Paragraph (a) removes requirements currently in the National Health Service Act 2006 concerning the content of the forward plan. Paragraph (b) removes the requirements for the forward plan to be prepared by the foundation trust's directors and for the directors to have regard to the views of the foundation trust's governors when preparing the forward plan.

Foundation trusts will no longer be mandated to set out information in the forward planning documentation around non-health service activity and income. The clause also removes the requirement for governors to be mandated to determine whether the foundation trust's forward plan interferes with the trust's health service activity.

As the Committee will know by now, and as a consequence of the abolition of Monitor and its merger with NHS England, NHS England will formally become responsible for the support and oversight of foundation trusts, which includes taking on Monitor's regulatory and intervention powers. That change will enable improved oversight and greater flexibility across the system. Provisions elsewhere in the Bill make the detailed changes, including formally giving NHS England responsibility for giving directions in relation to the content and form of foundation trust accounts. That includes specifying information to be included in the annual reports and accounts of foundation trusts.

The clause is simply part of transitioning the provider-based functions of Monitor into NHS England, ensuring continuity of oversight of foundation trusts' accounting and forward planning. NHS England will be able to provide fundamental advice and guidance to foundation trusts in the exercise of their functions. Provisions elsewhere in the Bill will formally allow NHS England to monitor the performance of foundation trusts and to take steps to intervene where necessary, which may take the form of advice and support. As we discussed on a previous occasion, however, it may also involve NHS England

requesting the trust to take action to remedy emerging issues. At the same time, the clause makes the requirements on annual plans more flexible, to reflect the direction of travel towards system-wide, rather than organisation-specific, planning.

I turn now to clause 54, which inserts proposed new section 47A into the National Health Service Act 2006 and allows an NHS FT to carry out its functions jointly with another person, should the foundation trust consider such arrangements to be appropriate. That would allow a foundation trust to exercise its healthcare delivery functions jointly with another foundation trust as part of a provider collaborative. The clause will make it easier for FTs to work with partners across the health system to develop integrated, seamless services in the best interests of patients.

Clause 55 amends sections 56, 56A and 56B of the 2006 Act, which relate to the merger, acquisition, separation and dissolution of NHS foundation trusts and NHS trusts. It removes the requirement that an application to acquire or merge an NHS FT with another NHS FT or an English NHS trust be supported by the Secretary of State if one of the parties is an NHS trust. NHS England will now consider each application, but the Secretary of State's role has been strengthened, as he must now approve such applications. However, NHS England will consider the applications and provide advice. That is in keeping with the policy intention that the Secretary of State should have a strengthened accountability role for NHS foundation trusts, in the light of the transfer of Monitor and NHS Trust Development Authority functions to NHS England. NHS England replaces Monitor in the relevant sections of the NHS Act 2006.

Like Monitor, NHS England has a duty to grant the application to merge, acquire or separate if it is satisfied that the necessary steps have been taken to prepare for an acquisition or the dissolution and establishment of new trusts. Additionally, the clause adds a further requirement to each of the sections, which provides that NHS England must refuse an application if the Secretary of State does not approve it. That strengthens the role of the Secretary of State in the process, and it will be for NHS England to take note of the Secretary of State's comments in taking forward its plans. The clause provides for enhanced oversight and places strategic decision making in the health system in the hands of NHS England, while also conferring a commensurate and important role on Ministers, in line with the direction of accountability set out in the Bill.

Clause 56 relates to the transitioning of the provider-based functions of Monitor and the NHS TDA into NHS England. That will allow NHS England to grant an application by an NHS foundation trust for dissolution. The clause confers the powers that rested with Monitor to transfer or provide for the transfer of property of an NHS foundation trust on its dissolution. Previously, on the dissolution of an NHS FT, Monitor had the power to transfer the property of the NHS FT to the Secretary of State. The clause amends that power so that, when making an order to dissolve an NHS foundation trust, NHS England now has the power to make an order to transfer, or provide for the transfer of, property and liabilities to another NHS FT, an NHS trust or the Secretary of State. The clause also includes a new duty for NHS England to include the transfer of any employees of a dissolved NHS FT in the transfer order.

Taken together, these clauses ensure that foundation trusts are able to play a central role in a more integrated and collaborative healthcare system. As part of that, the clauses also provide NHS England with the powers it will need to help support NHS FTs. I therefore commend clauses 51 to 56 to the Committee and propose that they stand part of the Bill.

Justin Madders (Ellesmere Port and Neston) (Lab): It is a pleasure to see you in the Chair this morning, Mrs Murray. I am glad you enjoyed Tuesday so much that you came back for another round. We will do our best to inform and entertain as we go along.

I am grateful to the Minister for setting out the Department's position on the clauses. We really need to have another go, don't we, at trying to understand the landscape for foundation trusts? I have already referred the Committee to the description of foundation trusts when they were first established, as vigorous, autonomous, business-like new organisations that would shake up the NHS and bring choice and competition into healthcare. As we know, there was no evidence that that model did any better than the previous standard trusts, once the high performers had been accounted for.

The Minister's contention that the clauses do nothing to impinge on a foundation trust's autonomy is quite the claim. The big change in the clauses is the stripping away of financial autonomy, as set out in clause 52, directly contradicting the many occasions when we have been told that the Bill is all about permissiveness, local decision making and accountability. In clause 55, we also see the Secretary of State giving himself yet more powers.

Clause 52(2) could, in effect, mean there was an indefinite block on foundation trusts using their own capital resources. Will there be any limitations on what is a broad power? I refer to the evidence from Dr Chaand Nagpaul, who touched on that:

"At the moment, we are seeing foundation trusts thinking about their budgets, community providers thinking about theirs, and general practice as well. There is not even collaboration between the community and the hospital. No foundation trust currently has the ability to say, for example, 'We will go beyond our budget and invest in the community—it may actually reduce our hospital admissions.' At the moment there is no structure or processes to enable collaboration even within the NHS."—[*Official Report*, *Health and Care Public Bill Committee*, 9 September 2021; c. 93, Q120.]

Dr Nagpaul sets out very well the lack of clarity that we still have about how finances will work at a local level within an ICB, and clause 52 gives foundation trusts even less autonomy in that respect.

On that point, I noted with interest today yet another *Health Service Journal* article, which talked about how integrated care partnerships may not be up and running for some time after the ICB has been set up. That raises questions about what their role is going to be in helping to form those capital priorities for an integrated care system.

In other evidence, Richard Murray said:

"The bit that I think is really uncertain is how the big hospital schemes get picked. That is the bit that looks very different. Obviously, there is a manifesto commitment."—

although we know that, in recent times, the Government have not been so keen to follow those commitments. He continued:

"There used to be a process by which it was determined whether providers could afford to repay—if they could do it through loans, or if there was a need system. That is now going

[Justin Madders]

off in a completely different place, and I think that is the bit that is not quite clear. How does that work within this system? Who gets to choose how those projects get picked, so to speak?"—[*Official Report, Health and Care Public Bill Committee*, 9 September 2021; c. 118, Q158.]

I appreciate that the point is slightly off-piste, but as we are talking about capital expenditure it is appropriate to raise it, and I am sure the Minister will take the opportunity in his response to set out that process in more detail. At the same time, can he set out in more detail what the guidance set out in proposed new section 42C would entail? Hopefully we will be able to set out some broad points in respect of that.

While we are on the Minister's response, will he consider the broader point we made on Tuesday about foundation trusts' focus on involvement of patients and the public and whether that needs to be strengthened across the board? He needs to think again about the whole question of accountability on ICBs.

To go back to the essential question, are foundation trusts now any different to plain, old-school NHS trusts? Is a foundation trust now a dodo? Is it extinct or on its way out? If an ambitious young chief executive of a trust were to approach the Minister and say they were thinking of putting in an application for foundation trust status, what would the Minister say to them about the benefits of such an application, both to their trust and to the wider healthcare system?

11.45 am

It could be argued that there is now a negative reason to not go down that route, as foundation trusts face risks that ordinary trusts do not face. They could decide to engage in some important capital works, carefully setting aside resources for a number of years to pay for them—not forgetting that with a £9 billion maintenance backlog there will be no shortage of projects to identify—but they face the risk that all that planning and prudence could be swept aside with a stroke of the pen by NHS England. Where is the incentive for them to invest in the future? What is the appeal process? Is a decision of that nature challengeable by a foundation trust? If the Minister can help us out by answering that, I would be obliged.

On the question of licensing in clause 51, we are none the wiser as to why that is still a requirement. Now that Monitor has gone, is there any longer a need for anything resembling licensing? Why do we need this roundabout way for NHS England to tell foundation trusts what they can and cannot do? Monitor used to be able to allow licence conditions to be modified where that would lead to certain, specifically defined, desirable outcomes, such as improving the quality of healthcare. Will that be possible under the new system?

Monitor has now left this place—it is deceased, it has fallen off the mortal coil—and NHS England will be there instead. It will be able to use its power to enable co-operation between providers of healthcare services without, as far as the Bill is concerned, having any need to explain why it is requiring that. The clause also extends the remit somewhat by applying to the NHS end and forcing it to co-operate with local authorities. Now that the trappings of the market are fading away, we need to understand better what licensing is going to achieve.

In the spirit of our many suggestions to help the Minister ease his workload, why not get officials to work on a new consolidation Act for the NHS? As we have seen, there are many amendments to the 2006 Act as a result of this Bill and other pieces of legislation, and it takes time to cross-reference so many parts, so one piece of legislation would be helpful for everyone, not least overworked shadow Ministers. Maybe the time to do that is when we have the next reorganisation in approximately two years' time, when the Prime Minister's latest integration plans come to the fore and we see that something else has to change. In the meantime, can the Minister set out clearly the purpose and function of the licensing process? I am sure we would all be grateful to hear about that.

Edward Argar: I am grateful to the shadow Minister for his suggestion of a consolidation Act. I can tell just how much he enjoys the sessions we spend in Committee and how eager he is that, no sooner do we finish, than we are back in another Bill Committee together. In terms of his gentle gibe about reorganisation in another two years, there was roughly a two-year gap between the 1999, then the 2001, then the 2003 and then the 2006 reorganisations of the NHS under the previous Government. I fear this is something that affects Governments of all types.

Justin Madders: Indeed, but the point that we would make is that there was such a mess to clear up after 18 years of Conservative Government that we had to do a lot of reorganisations. If the Minister can state for the record that there will be no reorganisations within a specified timescale, we would all be delighted to hear that.

Edward Argar: We must always retain flexibility so that the legislative framework reflects the evolving nature of healthcare provision in this country and we can we deliver what all our constituents want us to.

The hon. Gentleman touched on the importance of licensing. The licence applies to anyone providing NHS services, including the independent sector. With the system oversight framework, it provides a tool that helps to ensure quality across all types of providers in a consistent way, hence the importance that we still attach to it.

At the heart of the hon. Gentleman's speech were his points about foundation trusts, a 2004 innovation. The reason we are introducing these changes is that we recognise not only the ability of foundation trusts to be autonomous, but the need for them to collaborate and integrate. The aim is to create a framework that allows for local flexibility but brings together local services, recognising the synergies that need to exist between all healthcare providers in an area. With the ICB holding the ring, we get local flexibility, but we look at it the local system level rather than the individual provider level. I alluded to it jokingly, but as I promised in our last session I can confirm to him that I was correct that there are no current applications from NHS trusts to become foundation trusts. I said that I was relying on my memory, but I can confirm for the record that my memory was accurate.

The hon. Gentleman talked about the new hospitals programme and capital more broadly. While slightly stretching the scope of the debate, I think that is probably

relevant because he was talking about capital, so I am happy to accept that—subject to your judgment, of course, Mrs Murray—as being in scope. In terms of investment in new hospitals, the bottom line is that this is capital provided by the Treasury—by central Government—to build new hospitals where they are most needed. He will have seen the criteria and the approach set out for the next eight schemes, which are currently being considered. An expression of interest is the first stage of that process. A number of criteria are set out—for example, are there safety issues? Is there an urgent need? Will this facilitate transformation and improve patient experience? The criteria are set out publicly.

The next stage, which will take place next year, is the whittling down of the applications to a shortlist and further consideration. I believe it is entirely right that, guided by advice from officials and local NHS systems, Ministers make those decisions, because it is central Government money that is being invested directly in the schemes, rather than the normal capital allocations from NHS England to local NHS systems that are decided at local system level. This is additional, over and above the normal capital allocations.

The hon. Gentleman mentioned proposed new section 42C and asked what it is envisaged the guidance will say, what it will cover, and how it will work. Essentially, we envisage it setting out how and when NHS England and NHS Improvement will exercise the powers—for example, where a foundation trust's plans potentially put at risk the broader ICB plans for capital, unduly divert resources, or skew the capital allocation in a particular direction. We do not envisage their being used with any regularity, and hope that, as now, broadly, there is a collaborative approach. It is more informal now than envisaged under the provisions, but there is a collaborative approach.

In his broader remarks about the balance between autonomy and freedoms, the hon. Gentleman asked what I would tell a keen and ambitious NHS trust chief executive who was considering taking advantage of the spaces in the queue to become a foundation trust the advantages in doing so are. Essentially, I would say that they should consider what best reflects the local needs for their local healthcare system, because foundation trusts will of course retain freedoms around commercial borrowing and other existing freedoms. The powers that we are introducing act as a safeguard should they be used against the wider interest of the system. There are still advantages, but each NHS chief executive in that situation should consider carefully their own local circumstances and what is most effective in providing for their patients and service users.

My two final points go to what the hon. Gentleman said about the fear that the powers are significant and should be used only as the last resort, and his second point about whether there should be a greater willingness to allow NHS providers to decide how they spend their surpluses, rather than a regulator or central Government deciding. I might be paraphrasing, but I think those were his two key concerns. On his first point, the powers act as a safeguard to allow national-level intervention when local negotiation cannot resolve disputes. I have alluded to what we would use the guidance for, which is to add a bit of flesh to the bones. We think that is best set out in guidance rather than on the face of statute, as circumstances change over time and applying a narrow statutory test could hinder the aims of the clause, which would ensure that NHS spending overall is in the best interests of the public.

To the second point about whether it should be down to NHS providers and systems to determine how they spend surpluses or moneys that they have saved each year for a particular purpose, the hon. Gentleman is right that NHS trusts and foundation trusts operate as autonomous organisations that are legally responsible for maintaining their estates and providing healthcare services. That will continue, but only where there is a clear risk of a trust acting against the wider interest of the NHS system locally and an ICB would the controls be considered for application.

Justin Madders: The Minister is setting out the aims, but I am a little unsure what a foundation trust acting against the wider interest of the ICB would look like. Can he give us examples of where that might have happened?

Edward Argar: The hon. Gentleman tempts me to give a specific example. The reason we chose the flexibility of using guidance is that we cannot envisage every eventuality, so we will set out in guidance the process and approach. I will try to give him an illustrative example rather than a specific one, if he will allow me. If we have an ICB making collective decisions about where capital investment is most needed at a system level, and if we have a foundation trust with resources deciding to prioritise huge investment in one particular area, that might not necessarily reflect the broadly agreed local priorities in the ICB plan and the ICP plan for that area. I envisage such matters being resolved at an ICB level. I have certainly seen in this job and in a past life, as I suspect the hon. Member for Bristol South has, where informal resolution of these things is often the most effective way, so I would not envisage these powers being used often, but it is important that we have the flexibility that they bring. On that basis, I commend the clauses to the Committee.

Question put and agreed to.

Clause 51 accordingly ordered to stand part of the Bill.

Clauses 52 to 57 ordered to stand part of the Bill.

Clause 58

Transfer schemes between trusts

12 noon

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

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

Clause 59 stand part.

Government amendments 15 and 16.

That schedule 8 be the Eighth schedule to the Bill.

Edward Argar: As we have discussed, clauses 39 and 40 make it clear that the Secretary of State continues to have the ability to create new NHS trusts. Clause 58 is an integral part of ensuring that the NHS has the correct provider landscape necessary to deliver integrated care and to respond to emerging priorities.

The clause allows NHS England to make a transfer scheme relating to NHS trusts and NHS foundation trusts. Such a transfer scheme can provide for the transfer

[Edward Argar]

of property, rights, staff and liabilities from one NHS provider to another to ensure that the right resources can, when necessary, be transferred to support the delivery of services across the NHS.

NHS trusts and NHS FTs will be able to apply jointly to NHS England to make transfer schemes under the clause. NHS England, as the national regulator, may grant the application for the transfer scheme if it is satisfied that all necessary steps to prepare for the scheme have been undertaken. The process can ensure, for example, that all transfer schemes are in the best interests of patients and represent value for money for the taxpayer. Transfer schemes for NHS providers are crucial to ensuring that we have a flexible, adaptable provider landscape to deliver the best care to our patients.

Clause 59 introduces schedule 8 to the Bill, which amends chapter 5A of the National Health Service Act 2006, which relates to trust special administrators. Schedule 8 outlines the changes to the process and authorisation for the appointment of trust special administrators, including the reporting mechanisms.

A trust special administrator is appointed to take charge of the trust, at which point the trust board of directors—in the case of NHS foundation trusts, the governors—are suspended. Trust special administrators may be appointed by NHS England to exercise the functions of a chairman and directors of an NHS trust, or the governors, chairman and directors of a foundation trust, where that is necessary to secure sustainable and high-quality services and where other interventions to secure financial or clinical sustainability have been exhausted.

Schedule 8 co-outlines the changes to the process and authorisation for the appointment of trust special administrators, including the reporting mechanisms. The changes are part of transitioning the provider-based functions of Monitor and the NHS TDA into NHS England, and it does not represent a substantial change in policy approach. It also transfers delegated duties placed on the NHS TDA to NHS England in relation to the appointment of a trust special administrator to an NHS trust. It also transfers functions of Monitor to NHS England in relation to the appointment of a trust special administrator for NHS FTs.

The administrators are to be appointed by NHS England to make recommendations about actions to secure sustainable and high-quality services. NHS England must appoint a trust special administrator if required to do so by the Care Quality Commission. Otherwise, it may make the order to appoint only if it considers that to be in the interests of the health service and if the Secretary of State has given their approval.

The process remains broadly the same under schedule 8, giving NHS England the appropriate role in relation to NHS trusts and foundation trusts. However, one change I draw to the attention of the Committee is in relation to NHS trusts: both NHS England and the Secretary of State will receive the administrators' report, which will state which action, if any, either is to take. The schedule confers a shared duty on NHS England and the Secretary of State to consult one another before taking any decision on action.

The provisions enable NHS England to discharge its responsibility for the support and oversight of NHS trusts and foundation trusts, including taking on Monitor and the NHS TDA's regulatory and inspection powers in relation to such trusts. They provide transparency to the appointment process and its reporting mechanisms, and clarity to the system in securing and delivering sustainable and high-quality services when the trust providing them has been placed into administration. I commend the clauses and the schedule to the Committee.

Government amendment 15 will ensure that integrated care boards are consulted when the Care Quality Commission requires NHS England to make a trust special administration order and ensures that the process properly accounts for all future commissioning arrangements involving those boards. Proposed new section 65B(4)(b)(ii) introduced under paragraph 2 of schedule 8 retains the existing requirement for the Care Quality Commission to consult commissioners of services from the NHS trust in question. The commission considered that to be appropriate. However, it does not account for situations where, in future, an NHS trust may provide services in an integrated care board area without formally providing services to that integrated care board. For example, where an NHS trust ends up spanning two integrated care board areas, those boards may decide to have a lead commissioner of services from an NHS trust. The purpose of the amendment is to put beyond any doubt that any integrated care boards that might be impacted by a trust special administration order being triggered for an NHS trust should be consulted as part of the formal process.

Similarly, Government amendment 16 will ensure that integrated care boards are consulted when NHS England decides to make a trust special administration order and that the process properly accounts for all future commissioning arrangements involving ICBs. Proposed new section 65B(5)(b), introduced by paragraph 2 of schedule 8, retains the requirement for NHS England to consult commissioners of services from the NHS trust in question, if

"NHS England considers it appropriate".

However, that again does not account for situations where, in future, an NHS trust may provide services in an ICB area without formally providing services to that ICB. For example, where an NHS trust may end up spanning two integrated care board areas, those boards may decide to have a lead commissioner of services from a trust. The purpose of the amendment is to put beyond any doubt that any integrated care boards that might be impacted by a trust special administration order being triggered for an NHS trust should be consulted as part of that formal process.

Amendments 15 and 16 ensure that the trust special administration process reflects the role the ICBs will play and the different levels of autonomy and status between different NHS trusts and foundation trusts under the present system, putting the need for calibration and consultation at the heart of the measure. For those reasons, I ask the Committee to support the amendments.

Alex Norris (Nottingham North) (Lab/Co-op): It is a pleasure to serve with you in the Chair, Mrs Murray. There is not a tremendous amount to get excited about in these clauses and amendments, but I want to ask a couple of questions of the Minister.

On clause 58, it makes sense to provide for a time where there needs to be a transfer of property, rights or liabilities from one NHS trust or foundation trust to

another. Indeed, I suspect that our conversations about boundaries in earlier parts of the Bill are far from finished. That may have a knock-on impact on providers, so we may see it used in the near future. On the powers reserved for NHS England to create transfer schemes, it is not greatly surprising that it is the ultimate arbiter of applications. That is consistent with the rest of the Bill.

I could not tempt the Minister to cover one point in the final grouping on Tuesday evening, and I hope he might expand on it now. Where are the integrated care boards in this? Surely they would have a significant view about changes to the providers, and possibly the splitting up of providers—the Minister mentioned cross-border trusts, and how that might be led with lead providers. It is not inconceivable that the integrated care boards might have significant views, so should there not at least be a sense that their views have been sought? If not, there ought to be support, which would probably be desirable. In the previous grouping, we covered the fact that that was also true for trusts entering special measures and for trusts becoming foundation trusts. Again, there was no sense of what the ICB's role was. I do not think that the Minister mentioned that in his summing up. I hope that he might do so on this occasion.

I heard what the Minister said about Government amendments 15 and 16, which I have a lot more sympathy for. I raised this issue on Tuesday night. Where the Care Quality Commission and NHS England are involved in a trust failure situation, they should of course want the ICB to be a part of that process. I believe that the point the Minister made was that amendments 15 and 16 will amend the clause sufficiently to ensure that integrated care boards have their say in situations of failure. I hope he will clarify that ICBs in any such situation will get due consultation about what comes next.

I accept the Minister's point that clause 59 does not represent a material change in direction or policy from where we are today, but instead tidies up who is responsible and deals with new arrangements for NHS England, as set out earlier in the Bill. Again, there is not much of a reference to the ICBs. Hopefully we get clarity that the point of the amendments is to put that back in. If so, obviously we would support that, but I would wonder why that has not happened in other places—both in this group and previous ones too.

The Minister will love how granular this inquiry is. I ask it for no other reason than out of a genuine desire to know the answer; I am not trying to catch anybody out. Schedule 8 replaces section 65KD of the National Health Service Act 2006. Proposed new section 65KD mentions ICBs—I think it was about the only reference to them in the schedule, before the Government tabled amendments 15 and 16—and provides for what happens should an ICB fail to discharge its functions. In that case, under proposed new subsection (5)(b),

"the Secretary of State may exercise the functions of NHS England under section 14Z59(2), (3)(a) and (5)(a)",

which are introduced by the Bill.

Proposed new section 14Z59 is titled:

"Power to give directions to integrated care boards".

At that point, the Secretary of State has taken over NHS England's role and now acts as NHS England himself or herself. Can the Minister explain why that would be necessary? If we are saying that an ICB is part of a failure of circumstances, not discharging its functions properly, would not the first port of call traditionally be the centre—NHS England—to step in and provide support, or is there a judgment that the national leadership has failed too if the local leadership has failed, and therefore the Secretary of State must be the next link in the chain?

I am conscious that that is a granular query, but I think the provision departs from principles earlier in the Bill. It may well be that this is a very specific and niche example, in which case there is less to worry about, but I would like an explanation on that, and on where ICBs are in the grand processes around clause 58. When changes happen, what consultation does there have to be with them, and what support will they have?

Edward Argar: On the shadow Minister's central question about where ICBs fit in, he is right that we envisage their being, as we have discussed throughout, central to decision making in their locality. He is right to highlight that, as drafted, there was the potential for them to be regarded as not front and centre, hence Government amendments 15 and 16, which we hope add clarity and add that ICBs will be consulted, for example, when a special administrator is being appointed. We wanted to include them as part of that process. I fully acknowledge that, as drafted, there was a degree of ambiguity. That is why the Government introduced the amendments. I do not like having to amend my own legislation, but I think it important that we do so here.

Alex Norris: The Minister should not be shy about that at all. It is good sign, and shows that, after publication, he is still reflecting on the Bill and improving it as we go along. That is a strength rather than a weakness. However, these are amendments to schedule 8. I am surprised that there are no counterpart amendments for clause 58 or to the group that we discussed previously, which included clauses 39 to 42 and clauses 44 to 50. Why was the judgment made not to amend those in a similar way?

Edward Argar: We took the view that in this case there are very obvious consequences. In normal circumstances, we envisage collaborative work with, and the involvement of, the ICB. I was very keen that we were explicit here. It could be argued, as I would have done, that the clauses did not prohibit such co-operation, but I wanted to be very specific, because the appointment of a special administrator and the actions likely to be taken in that context could have profound impacts on the system. I wanted to be absolutely explicit about the need to involve ICBs.

The hon. Gentleman asked a detailed and granular question about paragraph 15(4) of schedule 8, and the powers in proposed new subsection (5)(b). The key point is that we would envisage it going up through the chain of accountability—chain of command is wrong word—but it is important that we recognise, as we do with the Bill, that the Secretary of State has a role in that chain of accountability to the House, to the public and to others. That theme has run through a lot of the discussions of the legislation, so we therefore think it appropriate to include the Secretary of State in that subsection.

Question put and agreed to.

Clause 58 ordered to stand part of the Bill.

Clause 59 accordingly ordered to stand part of the Bill.

12.15 pm

Schedule 8

TRUST SPECIAL ADMINISTRATORS: NHS TRUSTS AND NHS FOUNDATION TRUSTS

Amendments made: 15, in schedule 8, page 185, line 29, at end insert—

"any integrated care board in whose area the trust has hospitals, establishments or facilities, and"

(i) any integrated care board in whose area the trust has hospitals, establishments or facilities, and"

This amendment requires the Care Quality Commission to consult relevant integrated care boards before triggering the requirement for NHS England to make a trust special administration order for an NHS trust.

Amendment 16, in schedule 8, page 185, line 36, at end insert—

"(aa) any integrated care board in whose area the trust has hospitals, establishments or facilities,"—*(Edward Argar.)*

This amendment requires NHS England to consult relevant integrated care boards before exercising its discretion to make a trust special administration order for an NHS trust.

Schedule 8, as amended, agreed to.

Clause 60

JOINT WORKING AND DELEGATION AMENDMENTS

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

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

Clause 61 stand part.

That schedule 9 be the Ninth schedule to the Bill.

Edward Argar: As the Committee knows, one intention of the Bill is to create more flexibility, alongside the promotion of greater local integration. The clauses help to allow local bodies to work together in different ways to deliver effective health services.

Clause 60 enables NHS organisations, and any other bodies that may be prescribed in regulations, to commission and arrange services collaboratively, not only with other NHS organisations but with local authorities, combined authorities and other bodies that could be specified in regulations. Existing NHS legislative mechanisms make it difficult for the health and care system to work collaboratively and flexibly across different organisations, forcing local systems to adopt complex workarounds to be able to take joint decisions and pool budgets. In that context, back in the day, when I served in a local authority, we used section 75 of the 2006 Act as one mechanism for doing that with the local primary care trust.

In practice, however, those arrangements can sometimes be cumbersome and difficult to manage, and can delay making vital decisions. The new provisions inserted by the clause into the NHS Act 2006 will enable NHS organisations and any other bodies that may be prescribed in regulations to delegate functions to, or jointly exercise functions with, other NHS organisations, local authorities, combined authorities and other bodies as specified in regulations. Where functions are exercised jointly, the provisions will also enable those organisations to pool funds and form joint committees, facilitating partnership working and joint decision making at place and system level.

To ensure that delegation or joint exercise of functions does not lead to reduced accountability for delivering services, we have proposed appropriate safeguards in the clause. The Secretary of State will be able to set out in regulations which functions can and cannot be delegated, impose conditions in relation to delegation or joint exercise of functions, and specify the extent of such arrangements, for example. Furthermore, the parties will be able to agree terms as to the scope of the delegation arrangement. NHS England will have the ability to issue statutory guidance in relation to functions that are being delegated or jointly exercised under the provisions. The relevant body, as defined in the provision, must have regard to such guidance.

The provisions will replace those in existing sections 13Z, 13ZB and 14Z3 of the NHS Act 2006, which provide for the delegation of joint exercise of NHS England's functions. The clause also amends section 75 of the 2006 Act, which I just alluded to. That section details arrangements between NHS bodies and local authorities so that where a combined authority, for example, exercises an NHS function as part of arrangements under the new provisions, it can be treated as an NHS body. That is in line with how combined authorities are treated for other, similar joint working arrangements.

Clause 61 and schedule 9 focus on the delegation of functions. Clause 61 inserts a new section into the NHS Act 2006 that makes express the assumption that a general reference in the Act to a person's functions includes any functions that they are exercising on behalf of another person. That means, for example, that a reference in the Act to the functions of NHS England should cover any public health functions of the Secretary of State that NHS England may be exercising on their behalf under section 7A arrangements. The practical effect of this would be, for example, that any general duties that apply when NHS England is exercising its functions would also apply when it was exercising delegated functions. Until now, delegated functions have not been dealt with consistently in our health legislation. While it is not feasible, notwithstanding the suggestion of the shadow Minister, the hon. Member for Ellesmere Port and Neston, to remedy this issue across all health legislation in one consolidating Bill, this clause seeks to produce a more consistent approach.

Schedule 9 contains amendments to the NHS Act 2006 and other legislation to reflect the broader approach taken by clause 61 to delegated functions. Clause 61 also enables regulation to be made to create further exceptions where necessary to ensure that delegated functions are not covered by a provision where this would be inappropriate. Clause 61 addresses an important but technical legal issue in the Bill and is essential for enabling consistent and clear interpretation of our legislation.

These clauses are essential for ensuring that NHS organisations can collaborate effectively with each other as well as with other partners in the system. I therefore commend clauses 60 and 61 and schedule 9 to the Committee.

Justin Madders: Members will be relieved to hear that I will not detain the Committee long on this. Clause 60 does what the NHS itself has decided it needs. Over the last six years, we have had various iterations of this

integration process, joining things up around joint working, joint bodies and delegation. The provisions try to put all that in one place.

A recurring theme is clarity about the extent of crossovers between local authorities and the NHS. In that respect, proposed new section 65Z5 suggests that local authorities can carry out any function of an NHS body. Could the Minister say more about that? Does it mean that we could see local authorities commissioning—setting up GP surgeries in wellbeing centres? We are assuming that this is one-way and there is no reciprocal arrangement for the NHS to take on local authority functions, so that a foundation trust could not take on an arm's length management organisation or some other local authority function as a tax-efficient way of avoiding certain liabilities. Could the Minister respond on that?

I also wonder about care trusts, which were the original integrated working teams with the NHS and local authorities. They are rarely mentioned and were largely regarded as unsuccessful. Is there any intention to favour such genuinely integrated bodies? They were used in one recent case by an integrated care provider to get around some of the prohibitions on new trusts. Can the Minister tell us anything about where care trusts now fit into the landscape?

Given the joint nature of the provision, I would like to know why the guidance was published only by NHS England. Should it not have been a joint effort by the NHS and the Local Government Association? Was the LGA consulted and involved in the preparation of the guidance? That perhaps exposes that this is really about the NHS, not about integration across the board. As we have heard today, the ICPs will roll up at some later point, perhaps exposing the reality that this is going to be an NHS-dominated process.

Finally, on the pooling of funds, is there any limit on that? Is that envisaged to be an occasional opportunity, or will it be a more significant step down a road of full funding? Will the Minister set out whether the direction of travel will be quite as dramatic as possibly suggested by the clause?

Edward Argar: I am grateful to the shadow Minister for his support for the clauses and for the, as ever, perfectly sensible questions he poses. I hope to reassure him that the intention behind the clauses is not to create tax-efficient organisations or anything like that; it is to create the most efficient organisations for the delivery of joined-up care. I alluded to section 75 of the 2006 Act, which is an example of what many local authorities are doing already.

On guidance, I hope to reassure the hon. Gentleman that, throughout the genesis of the legislation, we worked collaboratively with the Local Government Association, reflecting local authorities more broadly. As we develop guidance, I am clear that the NHS, NHS England and the Government will continue to work with the association to ensure that local government's view is reflected in the drafting. A number of conversations have already taken place between officials and the LGA. Notwithstanding the debates we may have in this House or how the legislation emerges, I am clear that we will continue to work collaboratively throughout with all the partners involved, even in areas where we may disagree. We will always seek to work with them.

The hon. Gentleman expressed concerns—he will shake his head if I paraphrase him unfairly—about whether the legislation will allow for unlimited or unfettered delegation without checks and balances. Will we be able to transfer anything from an NHS trust to a local authority, or vice versa? The short answer is no. There will need to be a clear line of accountability between the body ultimately exercising the function and the delegating body. Safeguards ensure that any onward delegation is appropriate. That said, there may be circumstances in which a local authority would commission a particular healthcare service linked to other functions of the local authority delegated from the NHS. We would expect that clear accountability to be in place where that is done. We do not envisage the power being used regularly in that way, but there might be circumstances in which it would be.

Regulations may restrict what, where, when and how—and, indeed, to whom—delegations occur. The delegation agreement may also prevent further onward delegation of functions beyond a certain level. In addition—this goes back to the hon. Gentleman's point about the LGA—NHS England will, I expect, issue statutory guidance on delegation and joint committees, which would include scenarios, case studies, model delegation agreements and similar to show how, in practice, we envisage this working. The guidance would be statutory, and I envisage it being developed in concert with local authorities, represented by the Local Government Association—that is probably the most effective way of doing that.

I hope that I have given the hon. Gentleman some reassurance that there is nothing sinister—for want of a better word—intended in the clauses; they are merely meant to make things easier for local NHS bodies and local authorities, in particular, to co-operate more. That goes back to the integration at the heart of—the thread that runs through—all the legislation.

Question put and agreed to.

Clause 60 accordingly ordered to stand part of the Bill.

Clause 61 ordered to stand part of the Bill.

Schedule 9 agreed to.

Clause 62 ordered to stand part of the Bill.

12.30 pm

Clause 63

GUIDANCE ABOUT JOINT APPOINTMENTS

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

The Chair: With this it will be convenient to discuss clause 64 stand part.

Edward Argar: Before I speak to clauses 63 and 64, I crave your indulgence, Mrs Murray: I should have said to the shadow Minister that the previous clauses were about delegation from the NHS to local authorities, not the other way around. I would just like to put that on the record for him, because he expressed a concern about that.

Clauses 63 and 64 have been included in the Bill to help support ICBs and ICPs and to enhance integration across the health and care system. Clause 63 allows NHS England to issue guidance about appointing an

[Edward Argar]

individual to roles simultaneously in NHS commissioners and NHS providers, or in relevant NHS bodies on the one hand, and local authorities or combined authorities on the other. We have seen a number of clinical commissioning group and local authority joint appointments that have supported integration and been successful, and we would be keen to see those continue.

The clause further sets a requirement for these NHS bodies to have regard to such guidance when considering making a joint appointment. Joint appointments between organisations can support aligned decision making, enhance leadership across organisations and improve the delivery of integrated care. However, we believe that greater clarity is required to support organisations in making appropriate joint appointments, to avoid conflicts of interest that can be difficult to manage. Before issuing any new or significantly revised guidance, NHS England would be required to consult with appropriate persons.

Clause 63 will allow NHS England to publish a clear set of criteria for organisations to consider when making joint appointments and ensure regard is given to such guidance. That will also provide a safeguard against any conflicts of interest that may arise in the process of making joint appointments.

Clause 64 amends sections 72 and 82 of the National Health Service Act 2006, which deal with the co-operation between NHS bodies and the co-operation between NHS bodies and local authorities respectively. The clause inserts a new power for the Secretary of State to make guidance related to the existing co-operation duties between NHS bodies and between NHS bodies and local authorities. While the existing co-operation duties in sections 72 and 82 relate to both English and Welsh NHS bodies and local authorities, the guidance relates only to England, and the requirement to have regard to guidance issued under this new power will apply only to English NHS bodies and English local authorities.

Our intention is not to produce a single piece of co-operation guidance, which would risk being too general or too wide-ranging to be effective. Rather, we are considering discrete pieces of guidance in specific areas such as delivery of alcohol and drugs services, sexual and reproductive health, or hospital discharge services, to encourage and facilitate co-operation and integration in their delivery.

The clause also amends section 96 of the Health and Social Care Act 2012, which concerns the setting of licensing conditions for providers of NHS services. The licence, as we touched on earlier today, was established in 2013 so that providers of NHS services must meet to help ensure that the health sector works for the benefit of patients. Currently, conditions can be set on co-operation, but these provisions can apply only in certain circumstances.

The clause goes further: it supports system integration, promotes greater co-operation by removing the limitation on setting licence conditions on co-operation, and expands the range of bodies with which co-operation can be required. That will strengthen and reinforce the requirements on providers to co-operate and further strengthens the ability for NHS providers to deliver the system plan.

Co-operation is central to the intentions and underpinnings of this Bill. New guidance and expanding the role co-operation plays in the licensing regime will give organisations greater clarity about the practical expectations for co-operation, help the NHS to build on the innovation, working relationships and positive behaviours that have been seen over the past year, and further embed these behaviours across the health and care system. I therefore commend these clauses to the Committee.

Justin Madders: I am sure the Minister will be unsurprised to learn that the Opposition are a little wary of the powers in clause 63. One person doing two jobs is never ideal. I make an honourable exception for the hon. Member for Vale of Clwyd, who, in his other role, plays an important part in contributing to the wellbeing of the nation. Such exceptions are rare, and we think that two jobs for one person is never a sustainable or long-term solution.

We draw a distinction between a secondment, which obviously means that the position is by definition time limited and allows the post-holder to return to their original position. It is often good for career development, and that kind of mobility and interchange between the NHS and local authorities may be a very positive development, particularly with ICBs. However, the idea that there can be a joint appointment of a commissioner and a provider sounds wholly contradictory. Although the Minister has tried to allay our concerns by referring to guidance, it is clear that an NHS body needs to only "have regard" to that guidance. The question remains: at what point does someone step in when there is a clear and detrimental conflict of interest? We will see what the Minister has to say, but it we may need to keep a very close eye on that.

Clause 64 is a rather less obvious power grab by the Secretary of State, but it is one all the same. Clearly, he is not satisfied with the extent of co-operation between NHS bodies, because the Secretary of State now wants to be able to tell them how to co-operate. The guidance is to be issued, and a duty is to be placed on NHS bodies to follow it, or else face the consequences. What of? It is good old-fashioned persuasion—the willingness to work together for the greater good. It is actually the case that the Secretary of State wants two goes at this, as there are further powers to issue guidance in respect of NHS bodies and local authorities, which currently have to co-operate in order to advance the health and wellbeing of people.

Surely it is the case that they are doing that already. I cannot think of any reason why they would not co-operate, but what would be the sanction if they do not? Can the Minister tell us who he thinks these errant councils are that are not co-operating? Between myself, my hon. Friend the Member for Nottingham North and the Minister himself, we must have over a quarter of a century of experience in local government, and I cannot think of any occasion when councils were anything other than co-operative with the NHS. That is my experience, but if the Minister can help fill in the gaps, I would be most obliged.

Edward Argar: The shadow Minister tempts me to name and shame. He may be tempting me in vain. He raised three key points. One was about one person doing two jobs. To paraphrase him, he asked how that would work and why it was appropriate. He also mentioned conflicts of interest and asked why it was necessary and appropriate for the Secretary of State should have these powers.

To his first point, the clause is about driving greater integration. During my time as a member of Westminster City Council many years ago, we had a joint appointment. Our director of public health, if I recall correctly, was also an NHS appointment and she sat in both organisations in the senior management structure. It was extremely effective. Conflicts of interest, as we would envisage here, were managed both within the system and in accordance with guidance and principles of appointments and appropriate governance. That worked extremely well. It was not so much one person doing two jobs, but where the job was needed and the job description fitted both organisations, it delivered a real synergy and better outcomes.

There are circumstances where it can work. I would not have envisaged it being used essentially so that one person has multiple roles and jobs, but there are occasions when there is a benefit from someone sitting jointly in two organisations to help drive that integration and shared understanding. We can create, as we are doing here, mechanisms and structures to help drive integration and co-operation, but as the hon. Member for Nottingham North will know, and as the hon. Member for Bristol South will know from her time in the NHS, we can have those structures, but ensuring that organisations work effectively often relies on individuals, personal relationships and the trust that builds up at that level.

Karin Smyth (Bristol South) (Lab): My hon. Friend the Member for Ellesmere Port and Neston asked about care trusts, and the clause is partly designed for just that. The real problem with the clause and with joint appointments is that we already know that there are probably not enough senior, experienced people to go around to manage the difficult job of running a large hospital. The issue is ultimately about the focus on those hospitals and, indeed, on patient safety. The job of a chief executive of an NHS trust or foundation trust is an absolutely critical and quite busy one, but we are encouraging those people to take on an ICB leadership role, or joint roles in a local authority. We can either accept that those are large organisations that require particularly skilled people whom we pay properly, or we can simply merge the organisations. I would go for the former option. There are not enough of those people to go around. There is not enough variety of people. We are not encouraging the pipeline of talent, and we are not diversifying enough, and that is reflected in the NHS looking inward at itself. It is a big mistake to accept that we must have those joint appointments to bring the NHS together and make organisations collaborate.

Edward Argar: I am grateful to the hon. Lady, but those joint appointments have always gone on—they have existed for many years. The example I referred to was in about 2008 or 2009, and it worked extremely well, as both organisations benefited from that individual being a part of both. Our clauses seek to ensure that those joint appointments work well and effectively.

The hon. Member for Ellesmere Port and Neston asked why the powers sit with the Secretary of State rather than with the local NHS or NHS England. I am afraid that he will not tempt me into naming any particular local authorities or otherwise. The NHS is a critical part of our health and care system, but integration and co-operation need to go beyond the NHS itself, encompassing the role of local authorities in this space, which we all recognise. I hope that that co-operation will be consensual and voluntary, as the hon. Gentleman said, but it is important that the Secretary of State, with his accountability to this place and to the public, sits above that system. I would argue that he is in the best position to offer guidance on how that system can co-operate, and to help to resolve matters.

Justin Madders: One of the things that we have been told consistently is that integration and joint working are already well under way on the ground, and that the Bill is, in part, just putting a legislative seal on that work. If that is correct, why does the Secretary of State need those additional powers?

Edward Argar: Because we wish to take the opportunity to further drive forward the integration. The system has evolved, but we want to be more ambitious. The powers reflect the fact that the Secretary of State is able to take that wide perspective to most effectively see those two organisations coming together at a macro level—at the national level. That does not mean that I am denigrating in any way the evolution that is already occurring voluntarily in a whole range of areas around the country.

I sense that the hon. Gentleman is still unconvinced by joint appointments, so I will say a little more about them before I conclude, although I might still leave him unconvinced. There are already very few prohibitions on joint appointments, and we see an increasing number of them. In some cases, however, there could be a perception, or a reality, of a potential conflict of interest that could be difficult to manage or could lead to a perception of bias. We recognise that, which is why we have proposed the power to issue guidance to help organisations make the right joint appointments and to help them understand what factors to consider when deciding whether to proceed down the route of a joint appointment. The new powers for NHS England to issue guidance will ensure that there is a clear set of criteria against which to judge joint appointments when considering whether to make one. Bodies will have to have due regard to that guidance. I believe that the powers are proportionate.

Justin Madders: I am grateful to the Minister for giving way again. One of the critiques that we have developed —I hope that he has noticed—is that the Secretary of State has given himself an awful lot of powers and abilities to intervene. It seems highly incongruous that in the specific example of joint appointments, where there would be a clear role for the Secretary of State to intervene, he has not availed himself of the opportunity to do so.

12.45 pm

Edward Argar: As with so much else in the Bill, we are trying to future-proof it. Indeed, the shadow Minister and others made the point in a different context. Where are the powers? What are the options if there is disagreement, a dispute or a conflict? While not anticipating conflict, we are seeking to ensure that the Secretary of State is able to issue guidance to resolve any conflict or issues that may arise in that context. It is a pragmatic and proportionate measure to ensure that any such risks can be managed.

Question put and agreed to.

Clause 63 accordingly ordered to stand part of the Bill.

Clauses 64 and 65 ordered to stand part of the Bill.

Clause 66

THE NHS PAYMENT SCHEME

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

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

Amendment 84, in schedule 10, page 197, line 17, at end insert—

"(1A) The NHS payment scheme must ensure that the price paid to any provider of services which is neither an NHS Trust nor an NHS Foundation Trust cannot be different from the price paid to an NHS Trust or NHS Foundation Trust."

This amendment ensures payment to private providers can only be made at tariff price to prevent competition for services based on price.

Amendment 100, in schedule 10, page 197, line 17, at end insert—

"(1A) NHS England must obtain the agreement of the Secretary of State before publishing the NHS payment scheme."

This amendment ensures that the NHS payment scheme, which sets out the prices to be paid for NHS services, is approved by the Secretary of State.

That schedule 10 be the Tenth schedule to the Bill.

Edward Argar: I express my gratitude—I may be less grateful when I sum up—to hon. Members for tabling the amendments, and for the discussion that we are going to have about the NHS payment scheme. The Bill replaces the national tariff with a new NHS payment scheme, with additional flexibilities to allow the NHS to deliver population-based funding and more integrated care approaches. The NHS payment scheme, which will set rules about how commissioners pay providers for services, will apply to all providers of NHS services, including NHS trusts and foundation trusts, the voluntary sector and the independent sector.

Amendment 84 aims to ensure that payment to private providers can be made only at tariff price. While we will not introduce competition on price, rather than quality, there may be scenarios where it is appropriate to pay non-NHS providers different prices from those paid to NHS providers, to take account of differences in the cost of providing those services—for example, different staffing costs or a different range of services provided. There may also be cases where the financial regimes of different providers make it appropriate to set different prices or pricing rules. When setting any prices, NHS England will aim to ensure that the prices payable represent a fair level of pay for the providers of those services, as well as fair pay between providers of similar services.

I reassure the Committee that we do not expect to see the rules being used to give a premium to private providers to encourage them to enter the market. We do not expect to pay the independent sector 11.2% greater than the NHS equivalent cost, as the King's Fund briefing on independent sector treatment centres set out in 2009. Nor do we expect commissioners to pay for 100% of the contract value regardless of whether the activity reached the contracted level. Instead, the new payment scheme delivers what the NHS has asked for to implement its long-term plan. For that reason, we encourage Opposition Members not to press the amendment to a Division, but I may be pressing them in vain.

The Government will also, I am afraid, oppose amendment 100, which would require the NHS payment scheme to be approved by the Secretary of State. The NHS payment scheme will be published by NHS England, following consultation with relevant providers and commissioners, and, where relevant, the publication of an impact assessment. Integrated care boards and relevant providers will be able to make representations and formally object in response to consultations on the NHS payment scheme, as they can with the national tariff. Where the percentage of objections exceeds the prescribed threshold for either ICBs or relevant providers, or both, NHS England must further consult the representatives of the ICBs and providers that were objecting. NHS England may then publish a revised payment scheme, with another consultation for significant changes. It will also be able to publish the proposed scheme without amendment, but will be required to publish a notice stating that decision and setting out the reasons for it.

The Government are responsible for setting out overall funding for NHS England, who in turn will continue to be required to have regard to fair levels of reimbursement for providers in setting the details of the payment scheme. The Department and NHS England will continue to work closely together in the development of the NHS payment scheme, as we do with the national tariff. However, as a last resort, derived from clause 37 powers of direction, the Secretary of State will be able to require NHS England to share the NHS payment scheme before publication. The Secretary of State will also be able to direct NHS England not to publish a payment scheme without his approval, and about the contents of the payment scheme under his general powers of direction under clause 37.

Although we do not expect to need to use the powers of direction to intervene in this area, they can be used and will act as a further safeguard against unfair payment scheme provisions, as well as allowing for appropriate parliamentary accountability for funding flows in the NHS. The consultation requirements in schedule 10, and the general powers of direction, allow for sufficient Government oversight and accountability for the payment scheme, and further specific provisions would be inflexible and unnecessary. *[Interruption.]* I will shorten my remarks. [HON. MEMBERS: "No!"] I am happy to go on and on, but I fear the Committee might wish me to conclude. In that context, I will highlight to the Committee that, as with the national tariff, fair levels of reimbursement are a key principle of the legal framework reflected in NHS England's duty in subsection (6) of proposed new section 114A(6) to have regard to differences in providers' costs and the different range of services that they provide for the purpose of securing that prices and the overall payment scheme result in a fair level of pay to different types of providers.

I will also highlight and draw to the Committee's attention provisions in proposed new section 114C as inserted by schedule 10, which makes clear that, before publishing the payment scheme, NHS England must consult integrated care boards, relevant providers and any other person that NHS England thinks appropriate. It must also provide an impact assessment of the impact of the proposed scheme.

Karin Smyth: There is a lot of drawing up of complicated documents and costings and then a lot of complicated consultation and decisions on whether the Secretary of

State will or will not decide whether he wants to be involved in looking at what the final solution is. Does the Minister have any idea of when we might see the final NHS payment system under the new arrangement?

Edward Argar: I would not prejudge the passage of the legislation and how the House might judge it, but I look forward to such a scheme being introduced expeditiously, if I may put it that way to the hon. Member. I hope I can also reassure the Committee in respect of amendment 107, which was not selected but raised issues pertinent to the clause more broadly. This is important. It is right that the amendment was not selected—I appreciate that it was not tabled by a member of the Committee—but it does highlight issues that we need to put on the record. I appreciate the impulse behind it.

Although NHS staff pay and conditions are outside the scope of the proposed payment scheme and are protected by provisions made elsewhere, unions and other representative bodies may wish to be reassured that their members are able to go to work in appropriately funded services. I hope I have given reassurance on that point and set out why I feel the amendment, although I am grateful that it was not selected, would be unnecessary, as the Bill already requires NHS England to consult with integrated care boards, relevant providers and any other person the NHS thinks appropriate before publishing a payment scheme. It must also publish an impact assessment of the proposed scheme, ensuring that any potential consultation is properly informed of the potential effects of the scheme. I appreciate that the amendment was not selected, but I put those points on the record as I can understand the intent behind the amendment and I wanted to offer those reassurances. I hope I can persuade Opposition Members not to press amendments 84 and 100 to a vote, but I may be unlucky in that respect.

Clause 66 introduces schedule 10, which amends the Health and Social Care Act 2012 by repealing the national tariff and replacing it with the new NHS payment scheme. The national tariff has for many years improved access to services and driven up quality across the NHS, but as we move towards a more integrated system focused on prevention, joint working and more care delivered in the community, we need to update the NHS pricing systems to reflect new ways of working since the tariff was introduced, and in the light of the covid-19 pandemic.

The new NHS payment scheme will build on the success of the tariff. It will support stronger collaboration than ever before, with shared incentives for commissioners and providers of services to improve quality of care and promote sustainable use of NHS resources. The scheme will move away from a wholly payment-by-activity approach to an approach that supports more joined-up ways of delivering services, with commissioners and providers working together to deliver the best quality care.

The new payment scheme will remove perverse incentives for patients to be treated in acute settings and allow more patients than ever before to be treated closer to home and in the community. It will allow NHS England to guide the health system, through the development of guide prices for entire care pathways, while ensuring that local systems have the necessary flexibility to deliver high-quality care and use NHS resources sustainably.

The payment scheme will specify rules that commissioners must follow when determining prices paid to providers of NHS-funded healthcare services. It will allow significant flexibility over the current pricing scheme, and allow rules to set prices, formulas and factors that must be considered when determining prices paid. It also allows for in-year modifications to the rules, to reflect changes in the costs of providing services.

Crucially, the scheme will also allow the NHS to set prices for public health services commissioned by the NHS, on behalf of the Secretary of State, such as maternity screening, to allow for seamless funding streams for episodes of care. These changes to increase the flexibility and reduce transactional bureaucracy associated with the current tariff are, we believe, crucial to integrating care and tackling the elective backlog. I therefore commend this clause and schedule to the committee.

Alex Norris: Clause 66 is exceptionally important, so I cannot promise the same brevity as the Minister. I think the rules work slightly differently on the hard stop on a Thursday than they do on a Tuesday.

The Chair: Order. There is no hard stop on a Thursday.

Alex Norris: I am grateful for that clarification. If I am interrupted by colleagues in order to meet the conventional times, I will not take that as a kindness.

The clause governs how billions and billions of pounds will be spent every year, so it is surprising that it is so thin: three lines under clause 66 and a rather broad schedule 10. People could read into it whatever they want. My hon. Friend the Member for Bristol South made a good point that we could be in the business of filling that out for a very long period.

I am also surprised that the Minister is so reticent about the Secretary of State's involvement and that this power is solely reserved for NHS England. We are not suggesting that the Secretary of State would want to set payment levels for specific treatments; but the Secretary of State, either today or in the future, may want some sort of say over what is being incentivised in the system and how that extraordinary purchasing power works in practice, whether that is about innovation, prevention or incentivising buying British, for example. That is something in which I would expect there to be some political interest.

The Minister talked about using clause 37, but that is a rather blunt tool. What we offer in amendment 100 is much lighter and much less drastic than using the clause 37 powers. If the Government will not accept our amendment, I am surprised that they have not introduced a similar one of their own. Perhaps they may yet do so.

The history of the tariff and payments bears an airing here, because it informs our future. It is an itinerant journey, which all Governments of the day, of different political persuasions, have their fingerprints on. This is not a partisan issue; it is about getting this right for the future. The purchaser-provider split in the '90s and the development of various market and quasi-market systems was patchy and sporadic. That is a topic that has launched a thousand dissertations. Sometimes it feels like we aimed for payment by results, which is a noble cause, but in reality we can very easily get to payment by volume, and that is our challenge.

[Alex Norris]

Going back even further than that, it was even less satisfactory. Traditionally, we had funding mechanisms that were very hard to understand and worked by adding a bit to the previous year's allocations, and then really sophisticated people might make some downward adjustments for efficiencies and upward adjustments for assumed increases in activities. Inevitably, bits of the health service would get into trouble and would need bailing out, and new ideas would be dolloped out without much of a process. We have, to a certain extent, returned to that during covid. Block funding has given trusts one less thing to worry about. That was probably wise, but we would not want to do it forever.

The idea of the tariff was a variant of the 2012 Act. It could, I guess, incentivise competition on quality, but not really on price, as in a real market, as the Minister said. Prior to that, in the first decade of the century, the introduction of payment by results was one of the factors that allowed the longest successful period in the history of the NHS, which saw waiting lists come tumbling down—so much so that the demand for queue-busting private options evaporated and private providers became suppliers to the health service, rather than suppliers of private healthcare.

Payment by results, or pricing, can be a tool to tackle waiting lists. Given that Conservative Governments leave office with spiralling waiting lists, that is worth remembering for the future. Although that may be a discussion for another day, I want to ask the Minister whether he thinks NHS pricing is likely to be part of the recovery strategy. It is all well and good saying that this may take years and years to come to fruition, but what about now?

The historic decision back in the first decade of this century was that private providers should be paid the same as the cost of the NHS, so that there is no financial incentive to use the private sector. I think that is a wise principle, but it can and has been worked around. We have seen some very dodgy, spurious outsourcing of services, such as cleaning, which was an absolute disaster in Nottingham.

There are and have always been large swathes of the health services where payment by results or volume did not apply. One was mental health, where defining the product was far from easy, so it was very difficult to price. For many years, the mental health sector wanted to be part of this, but that never happened. That is much less of a priority for the sector now; it is just desperate for proper funding. It continues to struggle.

Of course, in such a system we will always have gaming and bureaucracy. Any system such as this gets gamed. Upcoding is one example, where the work that is billed for gets put into the highest-paying category. We have invoicing, chasing errors, and disputes over such coding, the actual volumes of work done and all the rest. That was hugely prevalent when payment by results first arrived for primary care trusts, and I think it is still with us in some form today. The cost of the market systems, data collection and processing is well above the cost of providing entirely necessary management information about cost and volumes.

Of course, that is not to make an argument for no prices at all. For decades, the NHS as a system did not really have any idea what anything cost. The accounts were not particularly well kept, and there were no data collection systems and staff doing analysis. As a result, the variations were huge, and that did not work in the interests of the system. I am arguing not for a no-cost regime, but for one that lands in a sensible place and does not become an industry in itself. At the moment, we have no idea, because what is on the face of the Bill is so broad, and the Minister is promising quite a long walk into the future with not a lot of certainty.

Many discussions about the long term plan, the formation of STPs—then accountable care systems, then integrated care systems, and now ICPs—and the rest have been about co-operation and collaboration, a return to non-market days, and a dilution of the commissioner-provider split, at least so far as NHS bodies are concerned. There will still be a strong current to say that there has to be some sort of tariff and benchmark as a guide, but some will say that there may be some sort of ability to vary as circumstances dictate—a kind of "Trust me, guv" arrangement whereby people of good will and common purpose can decide what is best, and that would be acceptable. To an extent, that flexibility is understandable if we are talking about the internal workings of an integrated, publicly provided NHS.

However, when we are talking about £10 billion more a year of contracts with private acute care providers, that is real money exiting the NHS bank account, so we need to be much more careful. That is where amendment 84 comes in: there has to be some sort of limitation on what private providers are paid. I was not at all convinced by the Minister's explanation that there might be different costs, because of course there are different costs, the No. 1 cost being the need to derive profit from the contract. That is already a big cost. Of course, that can be met by compromising on quality or through downward pressure on what staff receive, but that is also a bad thing, so I did not think that was a particularly persuasive argument.

When it comes to all this money going out to private providers, there really ought to be some standardisation of the contract. If amendment 84 were accepted, we would have greater assurance that this is something done based on need, not cost or convenience. We would much rather invest in the NHS itself, taking away any perverse incentives to lean on the private sector as a resource pool and any risk of sweetheart deals due to our reliance on the good will of for-profit organisations.

In conclusion, we do not want the Secretary of State to price up a hip operation, but we do think there ought to be some interest in what our purchasing does in this country, to ensure that it is as good as possible. I do not think we should be using the blunt and brutal tools in clause 37, so I hope that the Minister will think again about amendment 100—if not now, then at a later point in proceedings.

Ordered, That the debate be now adjourned.—*(Steve Double.)*

1.8 pm

Adjourned till this day at Two o'clock.